

ATHLETE REGISTRATION

Special Olympics
Georgia



Dear Special Olympics Athletes, Parents, and Guardians:

Through the power of sports, people with intellectual disabilities discover new strengths and abilities, skills and success. Our athletes find joy, confidence and fulfillment — on the playing field and in life. They also inspire people in their communities and elsewhere to open their hearts to a wider world of human talents and potential.

To register to become a Special Olympics athlete, please complete the enclosed forms:

- PARTICIPANT RELEASE FORM.** Please read the form, print the participant's name, sign, and date. **(You will only need to complete and sign this form once if you are 18 years of age or older)**

- ATHLETE MEDICAL FORM.** The Special Olympics Athlete Medical Form is designed to identify health concerns that are more common among people with intellectual disabilities. Please complete the Health History section on pages 1 and 2. If you do not understand any parts of the form, you may leave those parts blank. Please sign at the bottom of page 2. Page 3 of the Athlete Medical Form should be completed, signed and dated by a medical professional. **The Athlete Medical form must be completed every three years. (A licensed Medical Doctor, licensed Chiropractor, Physician's Assistant, Registered Nurse Practitioner or Doctor of Osteopathic Medicine can complete and sign the medical form)**

The Release Form and the Athlete Medical Form instruct you to complete additional forms in certain uncommon situations. If this applies to you or if you have any other questions, please contact Special Olympics Georgia at (229-292-5143) or david.crawford@specialolympicsga.org

Please submit registration forms to:

BY MAIL: Special Olympics Georgia
3998 Inner Perimeter Road, Suite A
Valdosta, GA 31602

OR

BY EMAIL: david.crawford@specialolympicsga.org

OR

ONLINE: You can find the new Athlete Medical Form on our website at:
<http://www.specialolympicsga.org/become-an-athlete/athletes/>

Thank you. We are excited you are part of the Special Olympics Movement!

PARTICIPANT RELEASE FORM

Special Olympics
Georgia



I want to take part in Special Olympics and agree to the following:

1. **Able to Participate.** I am able to take part in Special Olympics. I know there is a risk of injury.
2. **Photo Release.** Special Olympics organizations may use my picture, video, name, voice, and words to promote Special Olympics.
3. **Overnight Stay.** For some events, I may stay in a hotel, college dorm or someone's home. If I have questions, I will ask.
 - **SOGA Housing Policy –** Special Olympics Georgia (SOGA) usually provides housing for Athletes, Unified Partners and Coaches entered in each State Games. SOGA totals the number of male and female Athletes, Unified Partners and Coaches per agency and assigns room allotments based on those totals. When determining allotted room numbers, SOGA allocates and provides 4 persons of the same gender per room for a Double/Double or King room with a pullout, 2 persons of the same gender per room for a King room and 5 persons of the same gender per room for a Queen/Queen with a pullout. In dorm rooms, SOGA allots one bed per person. Athletes, Unified Partners, Coaches and general volunteers may not share a room with Athletes, Unified Partners, Coaches and general volunteers of the opposite sex.
4. **Emergency Care.** I consent to medical care if needed in an emergency, unless I check one of these boxes:
 - I have a religious or other objection to receiving medical treatment.
 - I do not consent to blood transfusions.

(If either box is checked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)
5. **Health Programs.** If I take part in a health program, I consent to health activities, exams, and treatment. This should not replace regular health care. I can say no to treatment or anything else any time.
6. **Personal Information.** I understand my information may be used and shared by Special Olympics to:
 - Make sure I am eligible and can participate safely;
 - Run trainings and events and share results;
 - Put my information in a computer system;
 - Provide health treatment, make referrals, consult doctors, and remind me about follow-up services;
 - Research, share, and respond to needs of Special Olympics participants (identifying information removed if shared publicly); and
 - Protect health and safety, respond to government requests, and report information required by law.

I can ask to see and revise my information. I can ask to limit how my information is used.
7. **Concussions.** I understand the risk of concussions and continuing to play sports with a concussion. I may have to get medical care if I have a suspected concussion. I also may have to wait 7 days or more and get permission from a doctor before I start playing sports again.

PARTICIPANT NAME (PRINT): _____

PARTICIPANT SIGNATURE (required if over 18 years old and signing on own behalf)

I have read and understand this release. If I have questions, I will ask. By signing, I agree to this form.

Participant Signature: _____ **Date:** _____

PARENT/GUARDIAN SIGNATURE (required if under 18 years old or has a legal guardian)

I am a parent or guardian of the Participant. I have read and understand this form and have explained the contents to the Participant as appropriate. By signing, I agree to this form on my own behalf and on behalf of the Participant.

Parent/Guardian Signature: _____ **Date:** _____

Printed Name: _____ **Relationship:** _____

(You cannot alter this form under any circumstances)

Athlete Medical Form – HEALTH HISTORY

(pages 1 & 2 to be completed by the athlete or parent/guardian/caregiver)



REGION/AREA/COUNTY:

DELEGATION/TEAM/AGENCY:

Must complete all items on this page

ATHLETE INFORMATION

PARENT GUARDIAN INFORMATION (if not own guardian)

First Name: Middle Name:

Name:

Last Name:

Phone: Cell:

Date Birth (mm/dd/yyyy): Female: Male:

E-mail:

Address (Street):

Emergency Contact Name: Same as Above:

Address (City, State, Zip):

Emergency Contact Phone (cell):

Phone: Cell:

Emergency Contact Relationship:

E-mail:

Does the athlete have a primary care physician? Yes No *If yes, list.*

Eye color: Ethnicity: (optional)

Physician Name: Physician Phone:

Athlete Employer, if any:

Insurance Policy (Company and Number):

I am my own guardian. Yes No

Does the athlete have any objections to emergency medical care?

No Yes *If yes, contact your local Program to get the Emergency Care Refusal Form.*

Does the athlete have (check any that apply):

- Autism Down syndrome Fragile X Syndrome
 Cerebral Palsy Fetal Alcohol Syndrome
 Other syndrome, please specify:

LIST ANY SPORTS THE ATHLETE WISHES TO PLAY:

Is the athlete allergic to any of the following (please list):

- Latex No Known Allergies
 Medications:
 Insect Bites or Stings:
 Food:

Has a doctor ever limited the athlete's participation in sports?

No Yes *If yes, please describe:*

List any special dietary needs:

List all past surgeries:

Does the athlete currently have any chronic or acute infection?

No Yes *If yes, please describe:*

Has the athlete ever had an abnormal Electrocardiogram (EKG) or Echocardiogram (Echo)? *If yes, select below and describe.*

Yes, had abnormal EKG Yes, had abnormal Echo

Does the athlete use: (check any that apply):

- Brace Colostomy Communication Device
 C-PAP Machine Crutches or Walker Dentures
 Glasses or Contacts G-Tube or J-Tube Hearing Aid
 Implanted Device Inhaler Pacemaker
 Removable Prosthetics Splint Wheel Chair

Has the athlete had a Tetanus vaccine in the past 7 years? No Yes

FAMILY HISTORY

Has any relative died of a heart problem before age 50? No Yes

Has any family member or relative died while exercising? No Yes

List all medical conditions that run in the athlete's family:

Athlete Medical Form – HEALTH HISTORY

(pages 1 & 2 to be completed by athlete or parent/guardian/caregiver)

Special
Olympics
Georgia



Athlete's Name:

HAS THE ATHLETE EVER BEEN DIAGNOSED WITH OR EXPERIENCED ANY OF THE FOLLOWING CONDITIONS

Loss of Consciousness	<input type="checkbox"/> No <input type="checkbox"/> Yes	High Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	Stroke/TIA	<input type="checkbox"/> No <input type="checkbox"/> Yes
Dizziness during or after exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes	High Cholesterol	<input type="checkbox"/> No <input type="checkbox"/> Yes	Concussions	<input type="checkbox"/> No <input type="checkbox"/> Yes
Headache during or after exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes	Vision Impairment	<input type="checkbox"/> No <input type="checkbox"/> Yes	Asthma	<input type="checkbox"/> No <input type="checkbox"/> Yes
Chest pain during or after exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hearing Impairment	<input type="checkbox"/> No <input type="checkbox"/> Yes	Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Shortness of breath during or after exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes	Enlarged Spleen	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hepatitis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Irregular, racing or skipped heart beats	<input type="checkbox"/> No <input type="checkbox"/> Yes	Single Kidney	<input type="checkbox"/> No <input type="checkbox"/> Yes	Urinary Discomfort	<input type="checkbox"/> No <input type="checkbox"/> Yes
Congenital Heart Defect	<input type="checkbox"/> No <input type="checkbox"/> Yes	Osteoporosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Spina Bifida	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Attack	<input type="checkbox"/> No <input type="checkbox"/> Yes	Osteopenia	<input type="checkbox"/> No <input type="checkbox"/> Yes	Arthritis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Cardiomyopathy	<input type="checkbox"/> No <input type="checkbox"/> Yes	Sickle Cell Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Heat Illness	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Valve Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Sickle Cell Trait	<input type="checkbox"/> No <input type="checkbox"/> Yes	Broken Bones	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Murmur	<input type="checkbox"/> No <input type="checkbox"/> Yes	Easy Bleeding	<input type="checkbox"/> No <input type="checkbox"/> Yes	Dislocated Joints	<input type="checkbox"/> No <input type="checkbox"/> Yes
Endocarditis	<input type="checkbox"/> No <input type="checkbox"/> Yes				

Difficulty controlling bowels or bladder No Yes
If yes, is this new or worse in the past 3 years? No Yes

Numbness or tingling in legs, arms, hands or feet No Yes
If yes, is this new or worse in the past 3 years? No Yes

Weakness in legs, arms, hands or feet No Yes
If yes, is this new or worse in the past 3 years? No Yes

Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet No Yes
If yes, is this new or worse in the past 3 years? No Yes

Head Tilt No Yes
If yes, is this new or worse in the past 3 years? No Yes

Spasticity No Yes
If yes, is this new or worse in the past 3 years? No Yes

Paralysis No Yes
If yes, is this new or worse in the past 3 years? No Yes

Describe any past broken bones or dislocated joints (if yes is checked for either of those fields above):

Epilepsy or any type of seizure disorder No Yes
If yes, list seizure type:

If yes, had seizure during the past year? No Yes

Self-injurious behavior during the past year No Yes

Aggressive behavior during the past year No Yes

Depression (diagnosed) No Yes

Anxiety (diagnosed) No Yes

Describe any additional mental health concerns:

List any other ongoing or past medical conditions:

PLEASE LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW (includes inhalers, birth control or hormone therapy)

Medication, Vitamin or Supplement	Dosage	Times per Day	Medication, Vitamin or Supplement	Dosage	Times per Day	Medication, Vitamin or Supplement	Dosage	Times per Day

Is the athlete able to administer his or her own medications? No Yes

If female athlete, list date of last menstrual period:

Name of Person Completing this Form Relationship to Athlete Phone Email

Athlete Medical Form – PHYSICAL EXAM

(to be completed by a Medical Professional only)



Athlete's Name:

MEDICAL PHYSICAL INFORMATION (TO BE COMPLETED BY EXAMINER ONLY)

Height	Weight	BMI (optional)	Temperature	Pulse	O2Sat	Blood Pressure	Vision	
<input type="text"/> cm	<input type="text"/> kg	<input type="text"/> BMI	<input type="text"/> C	<input type="text"/>	<input type="text"/>	BP Right <input type="text"/>	BP Left <input type="text"/>	Right Vision 20/40 or better <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A
<input type="text"/> in	<input type="text"/> lbs	<input type="text"/> Body Fat %	<input type="text"/> F	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Left Vision 20/40 or better <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A
Right Hearing (Finger Rub)	<input type="checkbox"/> Responds	<input type="checkbox"/> No Response	<input type="checkbox"/> Can't Evaluate	Bowel Sounds	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Left Hearing (Finger Rub)	<input type="checkbox"/> Responds	<input type="checkbox"/> No Response	<input type="checkbox"/> Can't Evaluate	Hepatomegaly	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Right Ear Canal	<input type="checkbox"/> Clear	<input type="checkbox"/> Cerumen	<input type="checkbox"/> Foreign Body	Splenomegaly	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Left Ear Canal	<input type="checkbox"/> Clear	<input type="checkbox"/> Cerumen	<input type="checkbox"/> Foreign Body	Abdominal Tenderness	<input type="checkbox"/> No	<input type="checkbox"/> RUQ <input type="checkbox"/> RLQ <input type="checkbox"/> LUQ <input type="checkbox"/> LLQ		
Right Tympanic Membrane	<input type="checkbox"/> Clear	<input type="checkbox"/> Perforation	<input type="checkbox"/> Infection <input type="checkbox"/> NA	Kidney Tenderness	<input type="checkbox"/> No	<input type="checkbox"/> Right <input type="checkbox"/> Left		
Left Tympanic Membrane	<input type="checkbox"/> Clear	<input type="checkbox"/> Perforation	<input type="checkbox"/> Infection <input type="checkbox"/> NA	Right upper extremity reflex	<input type="checkbox"/> Normal	<input type="checkbox"/> Diminished <input type="checkbox"/> Hyperreflexia		
Oral Hygiene	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	Left upper extremity reflex	<input type="checkbox"/> Normal	<input type="checkbox"/> Diminished <input type="checkbox"/> Hyperreflexia		
Thyroid Enlargement	<input type="checkbox"/> No	<input type="checkbox"/> Yes		Right lower extremity reflex	<input type="checkbox"/> Normal	<input type="checkbox"/> Diminished <input type="checkbox"/> Hyperreflexia		
Lymph Node Enlargement	<input type="checkbox"/> No	<input type="checkbox"/> Yes		Left lower extremity reflex	<input type="checkbox"/> Normal	<input type="checkbox"/> Diminished <input type="checkbox"/> Hyperreflexia		
Heart Murmur (supine)	<input type="checkbox"/> No	<input type="checkbox"/> 1/6 or 2/6	<input type="checkbox"/> 3/6 or greater	Abnormal Gait	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe below		
Heart Murmur (upright)	<input type="checkbox"/> No	<input type="checkbox"/> 1/6 or 2/6	<input type="checkbox"/> 3/6 or greater	Spasticity	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe below		
Heart Rhythm	<input type="checkbox"/> Regular	<input type="checkbox"/> Irregular		Tremor	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe below		
Lungs	<input type="checkbox"/> Clear	<input type="checkbox"/> Not clear		Neck & Back Mobility	<input type="checkbox"/> Full	<input type="checkbox"/> Not full, describe below		
Right Leg Edema	<input type="checkbox"/> No	<input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+		Upper Extremity Mobility	<input type="checkbox"/> Full	<input type="checkbox"/> Not full, describe below		
Left Leg Edema	<input type="checkbox"/> No	<input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+ Radial		Lower Extremity Mobility	<input type="checkbox"/> Full	<input type="checkbox"/> Not full, describe below		
Pulse Symmetry	<input type="checkbox"/> Yes	<input type="checkbox"/> R>L <input type="checkbox"/> L>R		Upper Extremity Strength	<input type="checkbox"/> Full	<input type="checkbox"/> Not full, describe below		
Cyanosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe		Lower Extremity Strength	<input type="checkbox"/> Full	<input type="checkbox"/> Not full, describe below		
Clubbing	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe		Loss of Sensitivity	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe below		

ATLANTO-AXIAL INSTABILITY (AAI)

- Athlete shows **NO EVIDENCE** of neurological symptoms or physical findings associated with spinal cord compression or atlantoaxial instability.
- Athlete has neurological symptoms or physical findings that could be associated with spinal cord compression or atlantoaxial instability and **must receive an additional neurological evaluation** to rule out additional risk of spinal cord injury prior to clearance for sports participation.

RECOMMENDATIONS (TO BE COMPLETED BY EXAMINER ONLY)

Licensed Medical Examiners: It is recommended that the examiner review items on the medical history with the athlete or their guardian, prior to performing the physical exam. If an athlete needs further medical evaluation please use the Special Olympics Further Medical Evaluation Form, page 4, to provide the athlete with medical clearance..

This athlete is **ABLE** to participate in Special Olympics sports without restrictions/limitations

This athlete is **ABLE** to participate in Special Olympics sports **WITH** restrictions/limitations →

This athlete **MAY NOT participate** in Special Olympics sports at this time and **MUST** be further evaluated by a physician for the following concerns:

Concerning Cardiac Exam

Concerning Neurological Exam

Other, please describe:

Acute Infection

Stage II Hypertension or Greater

O₂ Saturation Less than 90% on Room Air

Hepatomegaly or Splenomegaly

Additional Licensed Examiner's Notes and Recommended Follow-up:

- | | | |
|---|--|---|
| <input type="checkbox"/> Follow up with a cardiologist | <input type="checkbox"/> Follow up with a neurologist | <input type="checkbox"/> Follow up with a primary care physician |
| <input type="checkbox"/> Follow up with a vision specialist | <input type="checkbox"/> Follow up with a hearing specialist | <input type="checkbox"/> Follow up with a dentist or dental hygienist |
| <input type="checkbox"/> Follow up with a podiatrist | <input type="checkbox"/> Follow up with a physical therapist | <input type="checkbox"/> Follow up with a nutritionist |

Other/Exam Notes:

Licensed Medical Examiner's Signature

Date of Exam

Name: _____

E-mail: _____

Phone: _____ License: _____