

ATHLETE REGISTRATION FORM**Special Olympics**

State Special Olympics Program: _____ Local Area/Delegation: _____

Are you a new athlete to Special Olympics or Re-Registering? ☐ New Athlete ☐ Re-Registering

ATHLETE INFORMATION		
First Name:	Middle Name:	
Last Name:	Preferred Name:	
Date of Birth (mm/dd/yyyy):	Female	Male Other
Race/Ethnicity: Prefer not to answer		
American Indian/Alaskan Native	Asian	More than one race
Black or African American	Native Hawaiian or Other Pacific Islander	
White	Hispanic or Latino (specific origin group: _____)	
Language(s) Spoken in Athlete's Home (Optional): Check all that apply		
English	Spanish	Other (please list):
Street Address:		
City:	State:	Zip Code:
Phone:	E-mail:	
Sports/Activities:		
Athlete Employer, if any (Optional):		
Does the athlete have the capacity to consent to medical treatment on his or her own behalf? Yes No		
PARENT / GUARDIAN INFORMATION (required if minor or otherwise has a legal guardian)		
Name:		
Relationship:		
Same Contact Info as Athlete		
Street Address:		
City:	State:	Zip Code:
Phone:	E-mail:	
EMERGENCY CONTACT INFORMATION		
Same as Parent/Guardian		
Name:		
Phone:	Relationship:	
PHYSICIAN & INSURANCE INFORMATION		
Physician Name:		
Physician Phone:		
Insurance Company:	Insurance Policy Number:	
Insurance Group Number:		

ATHLETE RELEASE FORM**Special Olympics**

I agree to the following:

1. **Ability to Participate.** I am physically able to take part in Special Olympics activities.
2. **Likeness Release.** I give permission to Special Olympics, Inc., Special Olympics games organizing committees, and Special Olympics accredited Programs (collectively "Special Olympics") to use my likeness, photo, video, name, voice, words, and biographical information to promote Special Olympics and raise funds for Special Olympics.
3. **Risk of Concussion and Other Injury.** I know there is a risk of injury. I understand the risk of continuing to play sports with or after a concussion or other injury. I may have to get medical care if I have a suspected concussion or other injury. I also may have to wait 7 days or more and get permission from a doctor before I start playing sports again.
4. **Emergency Care.** If I am unable, or my guardian is unavailable, to consent or make medical decisions in an emergency, I authorize Special Olympics to seek medical care on my behalf, unless I mark one of these boxes:
 - I have a religious or other objection to receiving medical treatment. (Not common.)
 - I do not consent to blood transfusions. (Not common.)
 (If either box is marked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)
5. **Overnight Stay.** For some events, I may stay in a hotel or someone's home. If I have questions, I will ask.
6. **Health Programs.** If I take part in a health program, I consent to health activities, screenings, and treatment. This should not replace regular health care. I can say no to treatment or anything else at any time.
7. **Personal Information.** I understand that Special Olympics will be collecting my personal information as part of my participation, including my name, image, address, telephone number, health information, and other personally identifying and health related information I provide to Special Olympics ("personal information").
 - I agree and consent to Special Olympics:
 - using my personal information in order to: make sure I am eligible and can participate safely; run trainings and events; share competition results (including on the Web and in news media); provide health treatment if I participate in a health program; analyze data for the purposes of improving programming and identifying and responding to the needs of Special Olympics participants; perform computer operations, quality assurance, testing, and other related activities; and provide event-related services.
 - using my contact information for communicating with me about Special Olympics.
 - sharing my personal information confidentially with (i) researchers such as universities and public health agencies that are studying intellectual disabilities and the impact of Special Olympics activities, (ii) medical professionals in an emergency, and (iii) government authorities for the purpose of assisting me with any visas required for international travel to Special Olympics events and for any other purpose necessary to protect public safety, respond to government requests, and report information as required by law.
 - I have the right to ask to see my personal information or to be informed about the personal information that is processed about me. I have the right to ask to correct and delete my personal information, and to restrict the processing of my personal information if it is inconsistent with this consent.
 - **Privacy Policy.** Personal information may be used and shared consistent with this form and as further explained in the Special Olympics privacy policy at www.SpecialOlympics.org/Privacy-Policy.

Athlete Name:	
ATHLETE SIGNATURE (required for adult athlete with capacity to sign legal documents)	
I have read and understand this form. If I have questions, I will ask. By signing, I agree to this form.	
Athlete Signature:	Date:
PARENT/GUARDIAN SIGNATURE (required for athlete who is a minor or lacks capacity to sign legal documents)	
I am a parent or guardian of the athlete. I have read and understand this form and have explained the contents to the athlete as appropriate. By signing, I agree to this form on my own behalf and on behalf of the athlete.	
Parent/Guardian Signature:	Date:
Printed Name:	Relationship:

Participant Name:

Phone Number:

Area Number:

Local Program:

Email:

I have been vaccinated for COVID 19?

Yes

No

Month/Year of vaccine (final shot if 2 shot vaccine)

I understand I could get Coronavirus through sports, training, competition and/or any group activity at Special Olympics. I am choosing to participate in sports, competition and/or other Special Olympics activities at my own risk.

During the time these precautions are needed, I agree to the following to help keep me and my fellow participants safe: **(Please check all of the boxes in order to be eligible)**

If I have COVID-19 symptoms, I will stay at home and NOT go to any activities until 7 days after all of my symptoms are over or 10 days after a positive COVID test.

Special Olympics has educational materials available on COVID-19 and who is at high-risk that I have access to as needed.

I know that if I have a high-risk condition, I have more risk that I could get sick or die from COVID-19. If I have a high-risk condition, I should not go to Special Olympics events in person, until there is little or no Coronavirus in my community or I am fully vaccinated.

I know that before or when I get to a Special Olympics activity, they may ask me some questions about symptoms and exposure to COVID-19. They may also take my temperature. I will answer truthfully and participate fully.

I will keep at least 6 ft/2m from all participants at all times if required by current guidelines.

I will wear a mask at all times while at Special Olympics activities if required by current guidelines. I may not have to wear it during active exercise.

I will wash my hands for 20 seconds or use hand sanitizer before any activities. I will wash my hands any time I sneeze, cough, go to the bathroom or get my hands dirty.

I will avoid touching my face. I will cover my mouth when I cough or sneeze and immediately wash my hands after.

I will not share drinking bottles or towels with other people.

I will only share equipment when instructed to. If equipment must be shared, I will only touch the equipment if it is disinfected first.

If I get or have had COVID, I will not go to any in-person Special Olympics events until 7 days after my symptoms end or 10 days after a positive COVID test. I will go to my doctor and get written clearance before returning to any sport or fitness activities.

I understand that if I do not follow all of these rules, I may not be allowed to participate in Special Olympics activities during this time.

Please send all completed Athlete forms to Special Olympics Va, 21 Southgate Court, Suite 103, Harrisonburg, Va 22801 or email your completed and signed form to jgordon@specialolympicsva.org.

**WAIVER AND RELEASE OF LIABILITY, ASSUMPTION OF RISK AND INDEMNIFICATION
AGREEMENT FOR COMMUNICABLE DISEASES
SPECIAL OLYMPICS VIRGINIA**

In consideration of being allowed to participate in any way in Special Olympics sports training, competition or fundraising activities, the undersigned acknowledges, appreciates, and agrees that:

1. Participation includes possible exposure to and illness from infectious and/or communicable diseases including but not limited to MRSA, influenza, and COVID-19. While particular rules and personal discipline may reduce this risk, the risk of serious illness and death does exist; and,
2. I KNOWINGLY AND FREELY ASSUME ALL SUCH RISKS, both known and unknown, EVEN IF ARISING FROM THE NEGLIGENCE OF THE RELEASEES or others, and assume full responsibility for my participation; and,
3. I willingly agree to comply with the stated and customary terms and conditions for participation as regards protection against infectious diseases. If, however, I observe and any unusual or significant hazard during my presence or participation, I will remove myself from participation and bring such to the attention of the nearest official immediately; and,
4. I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, HEREBY RELEASE AND HOLD HARMLESS Special Olympics, Inc, Special Olympics Virginia their officers, officials, agents, and/or employees, other participants, sponsoring agencies, sponsors, advertisers, and if applicable, owners and lessors of premises used to conduct the event ("RELEASEES"), WITH RESPECT TO ANY AND ALL ILLNESS, DISABILITY, DEATH, or loss or damage to person or property, WHETHER ARISING FROM THE NEGLIGENCE OF RELEASEES OR OTHERWISE, to the fullest extent permitted by law.

I HAVE READ THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IF FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

Name of Participant: _____

Participant Signature: _____

Date signed: _____

FOR PARTICIPANTS OF MINORITY AGE (UNDER AGE 18 AT THE TIME OF REGISTRATION)

This is to certify that I, as parent/guardian, with legal responsibility for this participant, have read and explained the provisions in this waiver/release to my child/ward including the risks of presence and participation and his/her personal responsibilities for adhering to the rules and regulations for protection against communicable diseases. Furthermore, my child/ward understands and accepts these risks and responsibilities. I for myself, my spouse, and child/ward do consent and agree to his/her release provided above for all the Releasees and myself, my spouse, and child/ward do release and agree to indemnify and hold harmless the Releasees for any and all liabilities incident to my minor child's/ward's presence or participation in these activities as provided above, EVEN IF ARISING FROM THEIR NEGLIGENCE, to the fullest extent provided by law.

Name of Parent/Guardian: _____

Parent/Guardian Signature: _____

Date signed: _____

Athlete Medical Form – HEALTH HISTORY

(To be completed by the athlete or parent/guardian/caregiver and brought to exam)

**Special
Olympics**

Athlete First & Last Name: _____ **Preferred Name:** _____

Athlete Date of Birth (mm/dd/yyyy): _____ **Female** **Male** **Other**

STATE PROGRAM: _____ **E-mail:** _____

ASSOCIATED CONDITIONS - Does the athlete have (check any that apply):

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

ALLERGIES & DIETARY RESTRICTIONS

No Known Allergies _____

Latex _____

Medications: _____

Insect Bites or Stings: _____

Food: _____

ASSISTIVE DEVICES - 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

List any special dietary needs: _____

SPORTS PARTICIPATION

List all Special Olympics sports the athlete wishes to play: _____

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

No Yes

If yes, please describe: _____

SURGERIES, INFECTIONS, VACCINES

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, describe date and results

Yes, had abnormal EKG

Yes, had abnormal Echo

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

EPILEPSY AND/OR SEIZURE HISTORY

Epilepsy or any type of seizure disorder No Yes

If yes, list seizure type: _____

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

MENTAL HEALTH

Self-injurious behavior during the past year	No	Yes	Depression (diagnosed)	No	Yes
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Aggressive behavior during the past year	No	Yes	Anxiety (diagnosed)	No	Yes
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Describe any additional mental health concerns: _____

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(To be completed by the athlete or parent/guardian/caregiver and brought to Exam)

Athlete's First and Last Name: _____

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

Loss of Consciousness	No	Yes	High Blood Pressure	No	Yes	Stroke/TIA	No	Yes
Dizziness during or after exercise	No	Yes	High Cholesterol	No	Yes	Concussions	No	Yes
Headache during or after exercise	No	Yes	Vision Impairment	No	Yes	Asthma	No	Yes
Chest pain during or after exercise	No	Yes	Hearing Impairment	No	Yes	Diabetes	No	Yes
Shortness of breath during or after exercise	No	Yes	Enlarged Spleen	No	Yes	Hepatitis	No	Yes
Irregular, racing or skipped heart beats	No	Yes	Single Kidney	No	Yes	Urinary Discomfort	No	Yes
Congenital Heart Defect	No	Yes	Osteoporosis	No	Yes	Spina Bifida	No	Yes
Heart Attack	No	Yes	Osteopenia	No	Yes	Arthritis	No	Yes
Cardiomyopathy	No	Yes	Sickle Cell Disease	No	Yes	Heat Illness	No	Yes
Heart Valve Disease	No	Yes	Sickle Cell Trait	No	Yes	Broken Bones	No	Yes
Heart Murmur	No	Yes	Easy Bleeding	No	Yes	Dislocated Joints	No	Yes
Endocarditis	No	Yes	If female athlete, list date of last menstrual period: _____					

Describe any past broken bones or dislocated joints

(if yes is checked for either of those fields above):

List any other ongoing or past medical conditions:**Neurological Symptoms for Spinal Cord Compression and Atlanto-axial Instability**

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

PLEASE LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW

(includes inhalers, birth control or hormone therapy)

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

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

Name of Person Completing this Form	Relationship to Athlete	Phone	Email
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Athlete Medical Form – PHYSICAL EXAM(To be completed by a Licensed Medical Professional qualified to conduct exams & prescribe medications)

Athlete's First and Last Name: _____

Date of Birth: _____

MEDICAL PHYSICAL INFORMATION(To be completed by a Licensed Medical Professional qualified to conduct physical exams and prescribe medications)

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

SPINAL CORD COMPRESSION & ATLANTO-AXIAL INSTABILITY (AAI) (Select one)Athlete shows **NO EVIDENCE** of neurological symptoms or physical findings associated with spinal cord compression or atlanto-axial instability. **OR**Athlete has neurological symptoms or physical findings that could be associated with spinal cord compression or atlanto-axial instability and **must receive an additional neurological evaluation** to rule out additional risk of spinal cord injury prior to clearance for sports participation.**ATHLETE CLEARANCE TO PARTICIPATE (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 make a referral below and second physician for referral should complete page 4.

This athlete is **ABLE** to participate in Special Olympics sports without restrictions.This athlete is **ABLE** to participate in Special Olympics sports **WITH** restrictions. Describe ➡ _____This athlete **MAY NOT participate** in Special Olympics sports at this time & **MUST** be further evaluated by a physician for the following concerns:

Concerning Cardiac Exam

Acute Infection

O₂ Saturation Less than 90% on Room Air

Concerning Neurological Exam

Stage II Hypertension or Greater

Hepatomegaly or Splenomegaly

Other, please describe:

Additional Licensed Examiner's Notes and Recommended (but not required) Follow-up:

Follow up with a cardiologist

Follow up with a neurologist

Follow up with a primary care physician

Follow up with a vision specialist

Follow up with a hearing specialist

Follow up with a dentist or dental hygienist

Follow up with a podiatrist

Follow up with a physical therapist

Follow up with a nutritionist

Other/Exam Notes:

Name:

E-mail:

Signature of Licensed Medical Examiner

Exam Date

Phone:

License #:

Athlete Medical Form – MEDICAL REFERRAL FORM

(To be completed by a Licensed Medical Professional only if referral is needed)



Athlete's First and Last Name: _____

This page only needs to be completed and signed if the physician on page seven does not clear

the athlete and indicates further evaluation is required.

Athlete should bring the previously completed pages to the appointment with the specialist.

Examiner's Name: _____

Specialty: _____

I have been asked to perform an additional athlete exam for the following medical condition(s). Please describe.

Concerning Cardiac Exam

Stage II Hypertension or Greater

Hepatomegaly or Splenomegaly

Other, please describe:

In my professional opinion, this athlete MAY now participate in Special Olympics sports (indicate restrictions or limitations below):

Yes

Yes, but with restrictions (*list below*)

No

Additional Examiner Notes/Restrictions:

Examiner E-mail: _____

Examiner Phone: _____

License: _____

Examiner's Signature

Date

This section to be completed by Special Olympics staff only, if applicable.

This medical exam was completed at a MedFest event? Yes No

The athlete is a Unified Partner or a Young Athlete Participant? Unified Partner Young Athlete