

APPLICATION FOR PARTICIPATION (Medical Form)

(must be completed and signed by licensed examiner every 3 years)



COUNTY: _____ School/Agency: _____

SSN: _____ / _____ / _____ T-shirt Size: _____ Children: _____ OR Adult: _____

LAST NAME _____ FIRST _____ SEX _____ DATE OF BIRTH _____
M or F month/day/year

Street Number/Address _____ / _____ / _____

City _____ State _____ Zip Code _____ Home Phone (_____) _____

Parent/Guardian _____

Address (if different) _____ Work Phone (_____) _____

City _____ State _____ Zip Code _____

Emergency Contact (other than parent/guardian) _____ Emerg. Phone (_____) _____

Health Insurance Company _____ Ins. Policy # _____

Signature of parent/guardian/adult athlete completing form _____

FOR ATHLETES WITH DOWN SYNDROME -- Persons with Down syndrome should have a lateral x-ray of the cervical spine in hyperflexion and hyperextension. The interpretation of the radiographs should include measurements of the atlanto-dens interval.

Yes No Has an x-ray evaluation for atlantoaxial instability been done?

Yes No If yes, was it positive for atlantoaxial instability? (positive indicates that the atlanto-dens interval is 5mm or more)

IS THERE PRESENT OR A HISTORY OF (to be completed by parent/caregiver):

- | | | |
|---|---|--|
| Heart problems/high blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Tobacco use <input type="checkbox"/> Yes <input type="checkbox"/> No | Emotional/psychiatric/behavioral problems <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest pain <input type="checkbox"/> Yes <input type="checkbox"/> No | Major surgery or serious illness <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma/breathing problems with exertion <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Seizures/epilepsy/fainting spells <input type="checkbox"/> Yes <input type="checkbox"/> No | Heat stroke/exhaustion <input type="checkbox"/> Yes <input type="checkbox"/> No | Contact lenses/glasses/dentures/false teeth <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Easy bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No | Head injury/history of concussion <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hearing aid/hearing problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Bone/joint problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Immunizations (shots) are up-to-date <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blindness/vision problem <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle cell disease or trait <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet Needs (list below) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Absence of one kidney or testicle <input type="checkbox"/> Yes <input type="checkbox"/> No | Uses a wheelchair <input type="checkbox"/> Yes <input type="checkbox"/> No | Year of last tetanus shot _____ |

Other problems that would interfere with participation _____

Allergy to the following (list specific):

Food _____ Insect sting/bites _____

Medication _____

MEDICATIONS

| Medication Name | Dosage | Date Presc. | Times per day | Medication Name | Dosage | Date Presc. | Times per day |
|-----------------|--------|-------------|---------------|-----------------|--------|-------------|---------------|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

PHYSICAL EXAMINATION

| | | | | | | |
|----------------------|---------------|---|---------------------------------------|---|--|---|
| Blood Pressure _____ | Vision _____ | Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> | Oral Cavity <input type="checkbox"/> | Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> | Cardiovascular system <input type="checkbox"/> | Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> |
| Pulse _____ | Hearing _____ | <input type="checkbox"/> <input type="checkbox"/> | Extremities <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | Respiratory system <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| Weight _____ | Neck _____ | <input type="checkbox"/> <input type="checkbox"/> | Coordination <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | Gastrointestinal system <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| Height _____ | Skin _____ | <input type="checkbox"/> <input type="checkbox"/> | Reflexes <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | Genitourinary system <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| | | | | | Cranial nerves <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |

Other: _____

Primary MR Etiology/Category _____

I have reviewed the above health information and examined the athlete named in the application and certify that there is no medical evidence available to me which would preclude the athlete's participation in Special Olympics.

Restrictions _____

Examiner's Name: _____ Certification: MD DO DC PA ARNP

EXAMINER'S SIGNATURE _____ DATE: _____

OPTIONAL INFORMATION

Ethnic background: Asian African American Caucasian Hispanic Native American Other _____