



ATLANTO-AXIAL INSTABILITY RELEASE FORM

COUNTY: _____

SCHOOL/AGENCY: _____

ATHLETE NAME Last: _____ First: _____

DATE OF BIRTH: ____/____/____
month day year

CERTIFICATION BY PHYSICIANS

We have examined the athlete named in the application, who has Down Syndrome and who has been diagnosed as having Atlanto-axial Instability. We certify, based on our examinations of the athlete and our review of the health information contained in this application, that despite the diagnosis of Atlanto-axial Instability, this athlete is not medically precluded from participation in Special Olympics. We further certify that we have explained to the athlete named in this application, (and to the parent or guardian whose signature appears below, if the athlete is a minor), the medical risks associated with Atlanto-axial Instability and in particular, the risks associated with the athlete's participation in sports or events which, by their nature, may result in hyper-extension, radical flexion or direct pressure on the neck or upper spine. (Signatures of **two** physicians are required.)

Physician #1
Restrictions (if any): _____
Address: _____

Phone: _____ Date _____
Signature of Physician: _____

Physician #2
Restrictions (if any): _____
Address: _____

Phone: _____ Date _____
Signature of Physician: _____

CERTIFICATION OF ADULT ATHLETE

1. I have been informed by the physicians named above that I have Atlanto-axial Instability.
2. The risks associated with that condition, including the risks from participating in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, and football (soccer) have been fully explained to me by the physicians named above, and I fully understand the possible medical consequences if I participate in any of these sports or events.
3. Although I recognize and understand the risks and possible medical consequences, I certify that I am taking these risks knowingly and voluntarily, of my own free will, because of my desire to participate in Special Olympics, including any or all of the sports/events listed above, based on the certifications of the two physicians named above that I am not medically precluded from participating in Special Olympics.

Signature of Adult Athlete Date

OR CERTIFICATION OF PARENT/GUARDIAN

1. I have been informed by the physicians named above that my son/daughter has Atlanto-axial Instability.
2. The risks associated with that condition, including the risks from participating in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, and football (soccer) have been fully explained to me by the physicians named above, and I fully understand the possible medical consequences if my son/daughter participate in any of these sports or events.
3. Although I recognize and understand the risks and possible medical consequences, I hereby give my permission for my son/daughter to participate in Special Olympics, including any or all of the sports/events listed above, based on the certifications of the two physicians named above that my son/daughter is not medically precluded from participating in Special Olympics.

Signature of Parent/Guardian Date

I hereby certify that I have reviewed this release with the athlete whose signature appears above. I am satisfied, based on that review, that the athlete understands this release and have agreed to its terms.

Name (print): _____

Relationship to athlete: _____