# Special Olympics Kansas Medical / Release Form

Each participant in Special Olympics MUST have a current medical / release form on file in the SOKS Headquarters Office and in the possession of the coach prior to participating in any Special Olympics event/training/competition.

## DEMOGRAPHICS

TEAM NAME: _____ NUMBER: _____

Athlete's Social Security # _____ - _____ - _____ (if US Citizen) ☐ Male ☐ Female Date of Birth (month/day/year) _____/_____/_____

Athlete's Name _____

Athlete's Address _____ Athlete Home Phone # ( )

City: _____ State: Zip: Parent Email Address

Parent/Guardian's Name _____ Parent Primary Phone # ( )

Parent/Guardian's Address (if different than athlete) _____ Parent Cell Phone # ( )

Parent Secondary Phone # ( )

Emergency Contact (if other than parent/guardian) _____ Parent Employer

Emergency Phone #/Cell ( )

Health/Accident Insurance Company _____ Policy #

**PARTICIPATION AND CONSENT TO TREATMENT:** I hereby give permission for the participant named above to participate in Special Olympics. To the best of my knowledge, the athlete is physically and mentally able to participate in Special Olympics and full disclosure of the participant's medical history has been made to the physician whose signature appears below.
I acknowledge that the participant will be using facilities at his own risk and said parent/guardian, on his behalf, hereby releases, discharges and indemnities Special Olympics from all liability for injury to person or damage to property of himself and applicant.
I hereby irrevocably grant Special Olympics permission to record the above participant's likeness and/or voice for use by television, films, radio or printed media to further the aims of the Special Olympics.
If I am not personally present at Special Olympics activities, in case of necessity, you are authorized, on my behalf and at my account, to take such measures and arrange for such medical and hospital treatment as you may deem advisable for the health and well-being of the participant.

## HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | *Heart disease / heart defect / high blood pressure | ☐ | ☐ | Allergy: |
| ☐ | ☐ | *Chest pain | ☐ | ☐ | Medicines: _____ |
| ☐ | ☐ | *Seizures / epilepsy/fainting spells | ☐ | ☐ | Food: _____ |
| ☐ | ☐ | *Diabetes | ☐ | ☐ | Insect stings/bites: _____ |
| ☐ | ☐ | *Concussion or serious head injury | ☐ | ☐ | Special diet |
| ☐ | ☐ | *Major surgery or serious illness | ☐ | ☐ | Tobacco use |
| ☐ | ☐ | *Blindness / visual problem | ☐ | ☐ | Easy bleeding |
| ☐ | ☐ | *Asthma | ☐ | ☐ | Emotional / psychiatric / behavioral |
| ☐ | ☐ | Heat stroke / exhaustion | ☐ | ☐ | Sickle cell trait or disease |
| ☐ | ☐ | Contact lenses / glasses | ☐ | ☐ | Immunizations up to date |
| ☐ | ☐ | Hearing loss / hearing aid | ☐ | ☐ | Wheelchair |
| ☐ | ☐ | Bone or joint problem | ☐ | ☐ | Other (for additional space, use back of form): _____ |

Date of most recent tetanus immunization _____/_____/_____

(*) Requires physical examination

**Medications:**

Please print medication name, amount, date prescribed and number of times per day medication is given.

| Medication Name | Dosage | Date Prescribed. | Times per day | Medication Name | Dosage | Date Prescribed. | Times per day |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
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**NOTE:** If there is any significant change in the athlete's health, the athlete's condition ***should*** be reviewed by a physician before further participation.

**PARENT / GUARDIAN / ADULT PARTICIPANT SIGNATURE** _____

**DOWN SYNDROME:** ☐ **YES** ☐ **NO** **CHECK ONE: ATLANTO-AXIAL** ☐ **NEG.** ☐ **POS.**

**NOTE: If the athlete has Down syndrome, Special Olympics requires that the athlete have a full radiological examination establishing the degree, if any, of Atlanto-Axial instability before he / she may participate in any Special Olympics sport or event. Down syndrome forms are available from SOKS office.**

## MEDICAL CERTIFICATION

**A physical examination can only be conducted by a Medical Doctor (MD), Doctor of Osteopathy (DO), Doctor of Chiropractic (DC), Physician's Assistant, or an Advanced Registered Nurse Practitioner (ARNP).**

## PHYSICAL EXAMINATION

Blood pressure: _____/_____ Weight: _____ Height: _____

| Normal/Abnormal | | | Normal/Abnormal | | | Normal/Abnormal | | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Vision | ☐ | ☐ | Cardiovascular system | ☐ | ☐ | Cranial nerves |
| ☐ | ☐ | Hearing | ☐ | ☐ | Respiratory system | ☐ | ☐ | Coordination |
| ☐ | ☐ | Oral cavity | ☐ | ☐ | Gastrointestinal system | ☐ | ☐ | Reflexes |
| ☐ | ☐ | Neck | ☐ | ☐ | Genitourinary system | | | |
| ☐ | ☐ | Extremities | ☐ | ☐ | Skin | | | |

Other: _____

Primary MR Etiology/Category (If known): _____

I have reviewed the above health information and have performed the above examination on this athlete within the past 6 months and certify that the athlete can participate in Special Olympics.

RESTRICTIONS: _____

**EXAMINER'S SIGNATURE:** _____ **DATE** _____/_____/_____

**EXAMINER'S NAME:** _____

**ADDRESS:** _____

_____ **PHONE:** ( )