MEDICAL & CONSENT RELEASE

Special Olympics New York

For Participation in Special Olympics

REGION: _____

☐ Special Athlete
☐ Special Partner

PART 1: (ATHLETE INFORMATION)

Training Club Name: _____ ☐ Male ☐ Female Date of Birth (month/day/year)_____
Athlete's Name:_____
Athlete's Address:_____City:_____State: _____Zip:_____ Athlete Home Phone #:_____
Parent/Guardian:_____ Parent Primary Phone #:_____
Social Security #: _____ Parent Secondary #:_____
Emergency Contact (if other than parent/guardian):_____ Primary :_____
Health/Accident Insurance Company: _____ Policy #:_____

PART 2: (HEALTH HISTORY)

Yes	No	*To be completed by parent or guardian*
☐	☐	* Heart Disease / Heart Defect / High Blood Pressure
☐	☐	* Chest Pain
☐	☐	* Seizures / Epilepsy / Fainting Spells
☐	☐	* Diabetes
☐	☐	* Concussion / Serious Head Injury
☐	☐	Heat Stroke / Exhaustion
☐	☐	* Blindness / Visual Problem
☐	☐	Contact Lenses / Glasses
☐	☐	Hearing Loss / Hearing Aid
☐	☐	Bone or Joint Problem

Yes	No	
☐	☐	Allergy:_____
☐	☐	Medicines:_____
☐	☐	Insect Stings/Bites:_____
☐	☐	Special Diet
☐	☐	*Asthma
☐	☐	Tobacco Use
☐	☐	Easy Bleeding
☐	☐	Emotional / Psychiatric / Behavioral
☐	☐	Sickle Cell Trait or Disease
☐	☐	Immunizations up to date

Other: _____

Date of most recent tetanus immunization _____ / _____ / _____

Atlanto-Axial Instability Assessment for athletes with Down Syndrome (see back) Exam taken ☐ Y ☐ N Positive for ☐ Y ☐ N
Signature of parent / caregiver / adult athlete: _____ **Date:**_____

PART THREE: (PHYSICAL EXAMINATION)

Blood pressure: ____ /_____ Weight_____ Height_____

Normal	Abnormal		Normal	Abnormal		Normal	Abnormal	
☐	☐	Vision	☐	☐	Cardiovascular system	☐	☐	Neck
☐	☐	Hearing	☐	☐	Respiratory system	☐	☐	Coordination
☐	☐	Reflexes	☐	☐	Skin	☐	☐	Extremities

Other:_____ Primary MR Etiology / Category (if known): _____

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

EXAMINER'S SIGNATURE:_____ Date:_____
EXAMINER'S NAME:_____ MD License#: _____
ADDRESS:_____ PHONE#:_____

PART 4: (RELEASE STATEMENT)

INFORMED CONSENT PROVIDED BY:
Name:_____
Address:_____City:_____State: _____Zip:_____ Home Phone #:_____

Relationship to Athlete: ☐ Self (adult athletes only) ☐ Parent ☐ Legal Guardian ☐ Adult Family Member ☐ Approved Agency Staff

OFFICIAL SPECIAL OLYMPICS NEW YORK RELEASE FORM TO BE COMPLETED BY ADULT ATHLETE & PARENT OR GUARDIAN

I, _____am at least 18 years old and have submitted the attached application for participation in Special Olympics.

I AM THE PARENT/GUARDIAN OF _____,THE MINOR ATHLETE, on whose behalf I have submitted the attached application for participation in Special Olympics.
I hereby represent that the athlete has my permission to participate in Special Olympics activities.

I represent and warrant that, to the best of my knowledge and belief, I am physically and mentally able to participate in Special Olympics activities. I also represent that a licensed physician has reviewed the health information contained in my application and has certified, based on an independent medical examination, that there is no medical evidence which would preclude me from participating in Special Olympics. I understand that if I have Down Syndrome, I cannot participate in sports or events which, by their nature, result in hyper-extension, radical flexion or direct pressure on my neck or upper spine unless I and two physicians have completed the official "Special Release for Athletes with Atlanto-Axial Instability," available from the Special Olympics Chapter program in my state, or I have had a full radiological examination which establishes the absence of Atlanto-Axial Instability. I am aware that if I choose not to complete the "Special Release for Athletes with Atlanto-Axial Instability" form which establishes the absence of Atlanto-Axial Instability, I must have the radiological examination before I can participate in equestrian sports, gymnastics, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, and soccer.
I understand that participation in the Healthy Athletes venues is voluntary and that authorization can be withdrawn at any time. I understand that the provision of these health services is not intended as a substitute or alternative to regular care that has been received in the past or that may be recommended in the future. I understand that information that is gathered as part of the screening process may be used in group form (anonymously) to assess and communicate the overall health needs of athletes and to develop programs to address those needs.
Special Olympics has my permission, (both during and anytime after), to use my likeness, name, voice or words in either television, radio, film, newspapers, magazines, and other media, and in any form, for the purpose of advertising or communicating the purposes and activities of Special Olympics and/or applying for funds to support these purposes and activities.
If, during my participation in Special Olympics activities, I should need emergency medical treatment, and I am not able to give my consent or make my own arrangements for that treatment because of my injuries, I authorize Special Olympics to take whatever measures are necessary to protect my health and well-being, including, if necessary, hospitalization.

I, the athlete named above, have read this paper and fully understand the provisions of the release that I am signing. I understand that by signing this paper, I am saying that I agree to the provisions of this release.

Signature of Adult Athlete: _____ 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 has agreed to its terms.

Name (Print):_____ Relationship to athlete _____ (e.g. family member, teacher, coach, etc.)

Signature of Parent/Guardian: _____ Date:_____

MEDICAL & CONSENT RELEASE

Special Olympics New York

For Participation in Special Olympics

GENERAL INSTRUCTIONS

1 TYPE or PRINT clearly, using a ballpoint pen, when completing this form.
2 PRESS FIRMLY; all copies must be legible.
3 COMPLETE ALL PORTIONS of this form. Athletes are not allowed to train or compete until all portions are properly completed.
4 RETURN BOTH COPIES to your athlete's coach or regional office.

PART 1: ATHLETE INFORMATION

1 Include Region where the athlete participates.
2 Complete all requested information for the athlete.
3 Check box to indicate if athlete is a Special Partner or a Special Olympics Athlete.

PART 2: HEALTH HISTORY

1 If the athlete has Down Syndrome, indicate the date and results of the X-ray evaluation for Atlanto-Axial Instability. If no X-ray has been taken, check appropriate box; athlete will be prohibited from restricted sports until X-ray evaluation is completed. Permission to participate in these restricted sports WITH a positive Atlanto-Axial test requires that a "Special Release for Athletes with Atlanto-Axial Instability" be completed and attached to this form.
2 Respond to ALL health history questions by checking the appropriate box YES or NO.
3 Include comments at right for any 'YES' responses.
4 Be specific for "Other" and/or "Restrictions"; attach additional information/pages as necessary.

EXAMINER'S NOTE: If the athlete has Down Syndrome, Special Olympics requires a full radiological examination establishing any Atlanto-Axial Instability before he/she may participate in sports or events which, by their nature, may result in hyperextension, radical flexion or direct pressure on the neck or upper spine. The sports and events for which such a radiological examination is required are: equestrian, gymnastics, pentathlon, butterfly stroke, and diving starts in swimming, high jump, alpine skiing, snowboarding, squat lift, and football team competition (soccer).

PART 3: PHYSICAL EXAMINATION

1 This medical release may be completed by a Physician, Certified Practitioner or Physician's Assistant.
2 Complete all requested information of signatory. If using a stamp, all information must be included and legible on both copies.
3 SIGN and DATE (month/day/year) the form.
4 Indicate the signatory's credentials. M.D.'s MUST list their license number OR complete all requested information for their supervising Physician. Certified Nurse Practitioner and Physician Assistant MUST complete all requested information for their collaborating Physician.
5 This form is valid for up to three (3) years from the date of signature unless otherwise specified by a Physician.

PART 4: RELEASE FORM

1 Informed consent is valid for up to 3 years.
2. Any athlete, at least 18 years of age who possesses the ability to understand the provisions and can grant informed consent for him/herself can sign the release form.
3. If you have religious objections to approving the provision which gives Special Olympics permission to arrange for emergency medical treatment (including hospitalization) for the athlete if a medical emergency arises during his or her participation in Special Olympics, please cross it out and initial it on the front and attach a completed "Special Provisions Regarding Medical Treatment" form.

ADDITIONAL INFORMATION

RETURN BOTH COPIES TO YOUR ATHLETE'S COACH OR REGIONAL OFFICE

Additional information and assistance may be obtained from:

Special Olympics New York
504 Balltown Road
Schenectady, NY 12304-2290
(518) 388-0791
1-800-836-NYSO
FAX: (518) 388-0795

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