ATHLETE REGISTRATION

Special Olympics

Dear Special Olympics Athletes, Parents, and Guardians:

Through the power of sports, our athletes find joy, confidence and fulfillment — on the playing field and in life. Whether you are new to Special Olympics or have been involved for years, we are excited you are part of the movement!

To register or re-register as a Special Olympics athlete, please complete the enclosed forms:

- ☐ **REGISTRATION FORM.** This form asks for contact and other information.
- ☐ **RELEASE FORM.** This form goes over some important details about Special Olympics participation.
- ☐ **OPTIONAL LIKENESS RELEASE FOR SPONSORS.** If you would like to allow Special Olympics sponsors to use your photos, videos and stories, you may sign this form. This form is optional.
- ☐ **MEDICAL FORM.** This form is designed to identify health concerns that are more common among people with intellectual disabilities and clear an athlete to participate. Please fill out the Health History section on pages 1 and 2. If you do not understand any parts of the form, you may leave those parts blank to be discussed during the exam. The Physical Exam section on page 3 should be filled out and signed by a licensed medical professional (for example, Physician, Registered Nurse Practitioner, or Physician Assistant).

The Release Form and the Medical Form instruct you to complete other forms in certain uncommon situations. If this applies to you or if you have any other questions, please contact Ross County Special Olympics at 740-773-8044 ext.287 or cdavis@rossdd.org.

Please submit registration forms to:

Mail to: **Ross County Special Olympics**
167 W. Main Street
Chillicothe, Ohio 45601

Email to: **cdavis@rossdd.org**

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 Gender Identity	
Race/Ethnicity: ☐ Prefer not to answer ☐ American Indian/Alaskan Native ☐ Asian American ☐ More than one race ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White or Caucasian ☐ Hispanic or Latinx		
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 LIKENESS RELEASE FOR SPONSORS (OPTIONAL)

Special Olympics

Special Olympics relies on sponsors and partners to help support our mission. We often use photos, videos and stories of our athletes to show the impact of support by companies that sponsor Special Olympics. If you wish to allow your likeness to be used in this way, please read and sign below.

I agree to the following:

- I give permission to Special Olympics, Inc., Special Olympics games organizing committees, and Special Olympics accredited Programs (collectively "Special Olympics") and their sponsors and partners to use my likeness, photo, video, name, voice, words, and biographical information ("my likeness") to acknowledge the sponsors' and partners' support for Special Olympics.
- Special Olympics and its sponsors and partners will not use my Likeness to endorse commercial products or services.
- I understand I will not be compensated for the use of my Likeness.

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:**

Special Olympics Ohio

ATHLETE RELEASE FORM

I want to take part in Special Olympics and agree to the following:

1. **Able to Participate.** I am able to take part in Special Olympics. I know there is a risk of injury.

2. **Photo Release.** Special Olympics organizations may use my picture, video, name, voice, and words to promote Special Olympics.

3. **Overnight Stay.** For some events, I may stay in a hotel or someone's home. If I have questions, I will ask.

4. **Emergency Care.** I consent to medical care if needed in an emergency, unless I check one of these boxes:
   - ☐ I have a religious or other objection to receiving medical treatment.
   - ☐ I consent to emergency medical care, but I do not consent to blood transfusions.

   (If either box is checked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)

5. **Health Programs.** If I take part in a health program, I consent to health activities, exams, and treatment. This should not replace regular health care. I can say no to treatment or anything else any time.

6. **Personal Information.** I understand my information may be used and shared by Special Olympics to:
   - Make sure I am eligible and can participate safely;
   - Run trainings and events and share results;
   - Put my information in a computer system;
   - Provide health treatment, make referrals, consult doctors, and remind me about follow-up services;
   - Research, share, and respond to needs of Special Olympics participants (identifying information removed if shared publically); and
   - Protect health and safety, respond to government requests, and report information required by law.

   I can ask to see and revise my information. I can ask to limit how my information is used.

7. **Concussions.** I understand the risk of concussions and continuing to play sports with a concussion. I may have to get medical care if I have a suspected concussion. I also may have to wait 7 days or more and get permission from a doctor before I start playing sports again.

PARTICIPANT NAME: _____

PARTICIPANT SIGNATURE (required if over 18 years old and signing on own behalf)

I have read and understand this release. If I have questions, I will ask. By signing, I agree to this form.

Participant Signature: _____ Date: _____

PARENT/GUARDIAN SIGNATURE (required if under 18 years old or has a legal guardian)

I am a parent or guardian of the Participant. I have read and understand this form and have explained the contents to the Participant as appropriate. By signing, I agree to this form on my own behalf and on behalf of the Participant.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

Ross County

Special Olympics Ohio

ATHLETE CODE OF CONDUCT

Special Olympics is committed to the highest ideals of sport and expects all athletes to honor sports and Special Olympics.

All Special Olympics athletes and Unified Sports partners agree to the following code:

Sportsmanship

I will practice good sportsmanship. I will act in ways that bring respect to me, my coaches, my team and Special Olympics. I will not use bad language. I will not swear or insult other persons. I will not fight with other athletes, coaches, volunteers or staff.

Training and Competition

I will train regularly. I will learn and follow the rules of my sport. I will listen to my coaches and the officials and ask quetiosn when I do not understand. I will always try my best during trianing, divisioning and competitions. I will not "hold back" in premiminaries just to get into easier final heat.

Responsibility for My Actions

I will not make inappropriate or unwanted physical, verbal or sexual advances on others. I will not drink alcohol, smoke or take illegal drugs while representing Special Olympics at training sessions, competition or during Games. I will not take drugs for the purpose of improving my performance.

I will obey all laws and Special Olympics rules. I understand that if I do not obey this Code of Conduct my Program or a Games Organizing Committee may not allow me to participate.

PARTICPANT SIGNATURE (required if over 18 years old and signing on own behalf)
I have read and understand this code of conduct. If I have any questions, I will ask. By signing, I agree to this form.

Participant Signature: _____ Date: _____

Printed Name: _____

PARENT/GUARDIAN SIGNATURE (required if under 18 years old or has a legal guardian)
I am a parent or guardian of the Participant. I have read and understand this form and have explained the contents to the Participant as appropriate. By signing, I agree to this form on my own behalf and on behalf of the Participant.

Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

Special Olympics Ohio – Ross County
167 W. Main Street, Chillicothe, Ohio 45601 **Tel** 740-773-8044 ext.287 **Fax** 740-773-8052
Email rosscountytrailblazers@gmail.com **www**.rossspecialolympics.org

Special Olympics

CONCUSSION AWARENESS AND SAFETY RECOGNITION POLICY

Objective

It is Special Olympics' intent to take steps to help ensure the health and safety of all Special Olympics participants. All Special Olympics participants should remember that safety comes first and should take reasonable steps to help minimize the risks for concussion or other serious brain injuries.

Defining a Concussion

A concussion is defined by the Centers for Disease Control as a type of traumatic brain injury caused by a bump, blow, or jolt to the head as well as serial, cumulative hits to the head. Concussions can also occur from a blow to the body that causes the head and brain to move quickly back and forth—causing the brain to bounce around or twist within the skull. Although concussions are usually not life-threatening, their effects can be serious and therefore proper attention must be paid to individuals suspected of sustaining a concussion.

Suspected or Confirmed Concussion

A participant who is suspected of sustaining a concussion in a practice, game or competition shall be removed from practice, play or competition at that time. If a qualified medical professional is available on-site to render an evaluation, that person shall have final authority as to the removal or return to play of the participant. If applicable, the participant's parent or guardian should be made aware that the participant is suspected of sustaining a concussion.

Return to Play

A participant who has been removed from practice, play or competition due to a suspected concussion may not participate in Special Olympics sports activities until either of the following occurs (1) at least seven (7) consecutive days have passed since the participant was removed from play and a currently licensed, qualified medical professional provides written clearance for the participant to return to practice, play and competition or (2) a currently licensed, qualified medical professional determines that the participant did not suffer a concussion and provides written clearance for the participant to return to practice play immediately. Written clearance in either of the scenarios above shall become a permanent record.

The Centers for Disease Control website www.cdc.gov/concussion provides additional resources relative to concussions that may be of interest to participants and their families.

Athlete Medical Form-Health History

(pages 1 & 2 to be completed by the athlete or parent /guardian/caregiver)

Special Olympics Ohio

County:

Organization:

ATHLETE INFORMATION

First Name: Middle Name:

Last Name:

Date of Birth *(mm/dd/yyyy)*: Female: ☐ Male: ☐

Address (Street):

Address (City, State, Zip):

Phone: Cell:

E-mail:

Eye color: Ethnicity: (voluntary)

Athlete Employer, if any:

I am my own guardian. ☐ Yes ☐ No

Does the athlete have *(check any that apply)*:

☐ Autism ☐ Down syndrome ☐ Fragile X Syndrome

☐ Cerebral Palsy ☐ Fetal Alcohol Syndrome

☐ Other syndrome, please specify:

Is the athlete allergic to any of the following *(please list)*:

☐ Latex ☐ No Known Allergies

☐ Medications:

☐ Insect Bites or Stings:

☐ Food:

List any special dietary needs:

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 an abnormal Echocardiogram (Echo)? *If yes, select below and describe*
☐ Yes, had abnormal EKG ☐ Yes, had abnormal Echo

☐ PARENT ☐ GUARDIAN INFORMATION *(if not own guardian)*

Name:

Phone: Cell:

E-mail:

Emergency Contact Name: Same as Above: ☐

Emergency Contact Phone (cell):

Emergency Contact Relationship:

Does the Athlete have a Primary care Physician: ☐ Yes ☐ No *If yes, list*

Physician Name: Physician Phone:

Insurance Policy (Company and Number):

Does the athlete have any objections to emergency medical care?
☐ No ☐ Yes *If yes, contact your local Program to get the Emergency Care Refusal Form.*

List any sports the athlete wishes to play:

Has a doctor ever limited the athlete's participation in sports?
☐ No ☐ Yes *If yes, please describe:*

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

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

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

(pages 1 & 2 to be completed by the athlete or parent /guardian/caregiver)

Athlete's name

Special Olympics Ohio

Athlete's Name:

INDICATE IF THE ATHLETE HAS 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 heat 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						

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

Describe any past broken bones or dislocated joints *(if yes is checked for either of those fields above):*

Epilepsy or any type of seizure disorder ☐ No ☐ Yes

If yes, list seizure type:

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

Self-injurious behavior during the past year ☐ No ☐ Yes

Aggressive behavior during the past year ☐ No ☐ Yes

Depression (diagnosed) ☐ No ☐ Yes

Anxiety (diagnosed) ☐ No ☐ Yes

Describe any additional mental health concerns:

List any other ongoing or past medical conditions:

PLEASE LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW *(includes inhalers, birth control or hormone therapy)*

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

Is the athlete able to administer his or her own medications? ☐ No ☐ Yes **If female athlete, list date of last menstrual period:**

Athlete Signature *(if own guardian)* **Date**

Legal Guardian Signature *(only needed if not own guardian)* **Date**

Relationship to Athlete:

Athlete Medical Form-Physical Examination

(to be completed by a **Medical Professional** *only*

Special Olympics Ohio

Athlete's Name:

MEDICAL PHYSICAL INFORMATION *(TO BE COMPLETED BY EXAMINER ONLY)*

Height	Weight	BMI *(optional)*	Temperature	Pulse	O_2Sat	Blood Pressure		Vision
cm / in	kg / lbs	BMI / Body Fat %	C / F			BP Right:	BP Left:	Right Vision ☐ No ☐ Yes ☐ N/A 20/40 or better Left Vision ☐ No ☐ Yes ☐ N/A 20/40 or better

Right Hearing (Finger Rub)	☐ Responds	☐ No Response	☐ Can't Evaluate		
Left Hearing (Finger Rub)	☐ Responds	☐ No Response	☐ Can't Evaluate		
Right Ear Canal	☐ Clear	☐ Cerumen	☐ Foreign Body		
Left Ear Canal	☐ Clear	☐ Cerumen	☐ Foreign Body		
Right Tympanic Membrane	☐ Clear	☐ Perforation	☐ Infection	☐ NA	
Left Tympanic Membrane	☐ Clear	☐ Perforation	☐ Infection	☐ NA	
Oral Hygiene	☐ Good	☐ Fair	☐ Poor		
Thyroid Enlargement	☐ No	☐ Yes			
Lymph Node Enlargement	☐ No	☐ Yes			
Heart Murmur (supine)	☐ No	☐ 1/6 or 2/6	☐ 3/6 or greater		
Heart Murmur (upright)	☐ No	☐ 1/6 or 2/6	☐ 3/6 or greater		
Heart Rhythm	☐ Regular	☐ Irregular			
Lungs	☐ Clear	☐ Not clear			
Right Leg Edema	☐ No	☐ 1+ ☐ 2+	☐ 3+ ☐ 4+		
Left Leg Edema	☐ No	☐ 1+ ☐ 2+	☐ 3+ ☐ 4+		
Radial Pulse Symmetry	☐ Yes	☐ R>L	☐ L>R		
Cyanosis	☐ No	☐ Yes, describe			
Clubbing	☐ No	☐ Yes, describe			

Bowel Sounds	☐ Yes	☐ No			
Hepatomegaly	☐ No	☐ Yes			
Splenomegaly	☐ No	☐ Yes			
Abdominal Tenderness	☐ No	☐ RUQ	☐ RLQ	☐ LUQ	☐ LLQ
Kidney Tenderness	☐ No	☐ Right	☐ Left		
Right upper extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia		
Left upper extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia		
Right lower extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia		
Left lower extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia		
Abnormal Gait	☐ No	☐ Yes, describe below			
Spasticity	☐ No	☐ Yes, describe below			
Tremor	☐ No	☐ Yes, describe below			
Neck & Back Mobility	☐ Full	☐ Not full, describe below			
Upper Extremity Mobility	☐ Full	☐ Not full, describe below			
Lower Extremity Mobility	☐ Full	☐ Not full, describe below			
Upper Extremity Strength	☐ Full	☐ Not full, describe below			
Lower Extremity Strength	☐ Full	☐ Not full, describe below			
Loss of Sensitivity	☐ No	☐ Yes, describe below			

☐ **Athlete shows no evidence of any neurological symptoms or physical findings that could be associated with spinal cord compression or atlantoaxial instability.**

☐ **Athlete has neurological symptoms or physical findings that could be associated with spinal cord compression or atlantoaxial instability and must receive an additional neurological evaluation to rule out additional risk of spinal cord injury prior to clearance for sports participation.**

********RECOMMENDATIONS** *(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 is deemed to need further medical evaluation please utilize the Special Olympics Further Medical Evaluation Form, page 4, in order to provide the athlete with medical clearance.

☐ **This athlete is ABLE to participate in Special Olympics sports without restrictions/limitations**

☐ **This athlete is ABLE to participate in Special Olympics sports WITH restrictions/limitations:**

☐ **This athlete MAY NOT participate in Special Olympics sports at this time and MUST be further evaluated by a physician for the following concerns:**

☐ Concerning Cardiac Exam ☐ Acute Infection ☐ O_2 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 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:

Licensed Medical Examiner's Signature Date of Exam Phone: License:

Athlete Medical Form- Medical Referral Form

(to be completed by a **Medical Professional only if referral is needed)**

Special Olympics Ohio

Athlete's Name

This page only needs to be completed and signed if the physician on page three does not clear the athlete and indicates follow-up is required. Athlete should bring the previously completed pages to the appointment with the specialist.

Examiner's Name:

Specialty:

I have examined this athlete for the following medical concern(s):
Please describe

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

☐ **Yes, without restrictions** ☐ **Yes, but with restrictions** ☐ **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