



Dear Future Athlete, 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 before, we are excited you are interested in being part of the movement!

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

- ☐ **Athlete Intake Form.** This form asks for contact and other information.
- ☐ **Waivers, Releases, and Policies.** This form goes over some important details about Special Olympics participation.
- ☐ **Athlete Medical Care Refusal Form.** Only complete this form if you do not consent to emergency medical care on religious or other grounds and have marked a box under the Emergency Care provision in the Waivers, Releases, and Policies form.
- ☐ **Athlete Medical Form.** Physical exam that needs to be completed and signed by a licensed medical professional (for example, Physician, Registered Nurse Practitioner, or Physician Assistant).

If you have any questions when completing the forms, please contact Courtney Davis, Special Olympics Director, at (740)773-8044 ext.287 or RossCountyTrailblazers@sooh.org.

Please submit registration forms to:

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

Email to: RossCountyTrailblazers@sooh.org

To see the opportunities are local program provides, please follow Special Olympics Ohio – Ross County on Facebook at: <https://www.facebook.com/profile.php?id=100086443391878>

Enclosed, you will also find a document that outlines the sports that are offered in our programming with estimated registration deadlines for the upcoming seasons.

GO, TRAILBLAZERS!

Special Olympics Ohio – Ross County

167 W. Main Street, Chillicothe, Ohio 45601 **Tel** 740-773-8044 ext.287 **Fax** 740-773-8052

Email rosscountycloudblazers@gmail.com **www**.rossspecialolympics.org

Athlete Intake Form

Required for all athletes participating in Special Olympics.

Special Olympics



Local Special Olympics Program: _____

Athlete Information - To be completed by the athlete or parent/guardian/caregiver.

First name: _____ Last name: _____ Middle name: _____

Date of birth (dd/mm/yyyy): ____/____/____ Gender: Female Male Prefer not to answer

Email: _____ Phone number: _____ Mobile Landline

Home address: _____

Optional – Check all that apply:

Race / Ethnicity	American Indian / Alaskan Native Black / African American Middle Eastern / North African White / Caucasian Other: _____	Asian American Hispanic / Latino Native Hawaiian / Other Pacific Islander Unknown Prefer not to answer
Language(s) Spoken by Athlete	English French Spanish Other (please list): _____	American Sign Language (ASL)

Parent/Guardian Information - Required if minor or otherwise has a legal guardian.

First Name: _____ Last Name: _____ Relationship to athlete: _____

Email: _____ Phone number: _____ Mobile Landline

Home address: _____

Emergency Contact

Same as Parent/Guardian

First name: _____ Last name: _____ Phone number: _____ Mobile Landline

Relationship to athlete: Parent/guardian Caregiver Family member Healthcare provider Coach Other

Associated Conditions - Mandatory

Associated Conditions	Autism Marfan Syndrome Other	Cerebral Palsy Spina Bifida Unknown	Down Syndrome Epilepsy	Fetal Alcohol Syndrome Fragile X Syndrome
Check all that apply:				
Please specify other known intellectual disability diagnoses:				

Assistive Devices and Accommodations - Do you use any of the following? Check all that apply:

Mobility	Walker Prosthetics	Braces or crutches None	Wheelchair	Removable orthotics
Lifestyle Aids	CPAP None	Dentures	Glasses, contact lenses, or protective eyewear	
Communications	Hearing Aid	Communication devices	Sign Language	None
Medical Devices	Implantable cardioverter defibrillator (ICD) VP Shunt	Pacemaker	Implantable device for seizure management None	
Do you have a specific dietary requirement?	Yes	No	If yes, please specify:	
Do you use other assistive devices?	Yes	No	If yes, please specify:	

General Health Questions

Do you have a heart condition?	Yes	No
Do you have asthma?	Yes	No
Do you have diabetes that requires you to take insulin?	Yes	No
Do you have a vision impairment?	Yes	No
Do you have a hearing impairment?	Yes	No
Do you have a bleeding disorder?	Yes	No
Has a doctor ever limited your participation in sports?	Yes	No
Do you have epilepsy or any type of seizure disorder?	Yes	No
Do you have sickle cell disease?	Yes	No

Have you ever had a concussion?	Yes	No	If yes, please specify how many in your lifetime: _____ Date of last one (mm/yyyy): _____
Do you have behavioral, mental health, and/or sensory conditions?	Yes	No	If yes, please specify:
Do you have severe allergies that requires the use of an EpiPen?	Yes	No	If yes, please specify if it is to any of the following: Insect stings Medication/drugs Food Latex Other (please specify): _____

Medication and Treatment - Please list:

Are you taking any prescription or over-the-counter medications or treatments? (Including birth control pills, insulin, multivitamins allergy shots or pills, EpiPen, asthma inhalers, epilepsy medication, anti-inflammatory medication, supplements of any kind. etc.)

Yes No

If yes, please list:

Medication, Vitamin, or Supplement Name	Dosage	Times per day

Medication, Vitamin, or Supplement Name	Dosage	Times per day

Name of person completing the form: _____

Today's date (dd/mm/yyyy): ____/____/____

Is this form being completed by someone other than the athlete? Yes No

If yes, please select the relationship to athlete:

Relationship to athlete: Parent/guardian Caregiver Family member Healthcare provider Coach Other

Special Olympics encourages all participants to get a yearly physical examination.

WAIVERS, RELEASES, AND POLICIES

Please read the following information and check boxes fully before signing.

I agree to the following:

1. **Ability to Participate.** I am physically able to take part in Special Olympics activities, and will abide by all applicable rules, requirements and codes of conduct.
2. **Likeness Release.** I give permission to Special Olympics, Inc., Special Olympics games organizing committees, Special Olympics accredited Programs (collectively "Special Olympics"), as well as official Special Olympics supporters and partners that have authorization from Special Olympics, to use my likeness, photo, video, name, voice, words, biographical information and similar or related material (my "likeness") to promote Special Olympics and raise funds for Special Olympics. I understand that my likeness may be used in all forms of media in local or global campaigns – including those by supporters and partners of Special Olympics – but understand that my likeness will not be used to endorse commercial products or services. I understand that I will not be compensated for the use of my likeness.
3. **Emergency Care.** If I am unable, or my guardian is unavailable, to consent or make medical decisions in an emergency, I authorize Special Olympics to seek medical care on my behalf, unless I mark one of these boxes:

☐ I have a religious or other objection to receiving medical treatment.
☐ I do not consent to blood transfusions.
(If either box is marked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)
4. **Overnight Stay.** For some events, overnight accommodations may be required. If I have questions, I will contact my Special Olympics Program.
5. **Health Programs.** If I take part in a health program, I consent to health activities, screenings, and treatment. This should not replace regular health care. I have the right to decline Health programming treatment (which is different from sideline or emergency medical care) at any time."
6. **Personal Information.** I understand that Special Olympics will be collecting my personal information as part of my participation, including my name, image, address, telephone number, health information, and other personally identifying and health related information I provide to Special Olympics ("personal information").

I agree and consent to Special Olympics:

- using my personal information in order to: make sure I am eligible and can participate safely; run trainings and events; share competition results (including on the Web and in news media); provide health treatment if I participate in a health program; analyze data for the purposes of improving programming and identifying and responding to the needs of Special Olympics participants; perform computer operations, quality assurance, testing, and other related activities; and provide event-related services.
- using my contact information for communicating with me about Special Olympics.
- sharing my personal information confidentially with (i) researchers such as universities and public health agencies that are studying intellectual disabilities and the impact of Special Olympics activities, (ii) medical professionals in an emergency, and (iii) government authorities for the purpose of assisting me with any visas required for international travel to Special Olympics events and for any other purpose necessary to protect public safety, respond to government requests, and report information as required by law.
- I have the right to ask to see my personal information or to be informed about the personal information that is processed about me. I have the right to ask to correct and delete my personal information, and to restrict the processing of my personal information if it is inconsistent with this consent.

Privacy Policy. Personal information may be used and shared consistent with this form and as further explained in the Special Olympics privacy policy at www.SpecialOlympics.org/Privacy-Policy.

SYMPTOMS FOR SPINAL CORD COMPRESSION and ATLANTOAXIAL INSTABILITY (For athlete with Down syndrome only)

If I (or the athlete) have been diagnosed with or experienced any of the following symptoms that have increased in severity over the past three years – difficulty controlling bowels or bladder; numbness or tingling in legs, arms, hands, or feet; weakness in arms, legs, hands or feet; burner/stinger/pinches nerve, pain in neck, back shoulders, arms, hands, buttocks, legs or feet; spasticity or paralysis – I must obtain a review and permission from a licensed medical practitioner to train and/or participate in Special Olympics activities.

WAIVER AND RELEASE OF LIABILITY / ASSUMPTION OF RISK / INDEMNIFICATION

In consideration of being allowed to participate in any way in Special Olympics activities, the undersigned acknowledges, appreciates, and agrees that:

1. While particular rules and personal discipline may reduce this risk, the risk of illness (including communicable diseases), injury (including concussion), disability, and death does exist;
2. If I observe any unusual or significant hazard during my presence or participation, I will remove myself from participation and bring such to the attention of the nearest Special Olympics representative immediately; and,
3. **I understand the risks involved with participation in Special Olympics activities. I fully accept and assume all risks and all responsibility for losses, costs, and damages I may incur as a result of my participation. To the fullest extent of the law, I release and agree not to sue any Special Olympics organization, its directors, agents, volunteers, and employees, other participants, sponsoring agencies, sponsors, advertisers, and, if applicable owners and lessors of premises on which any Special Olympics activity is occurring ("Releasees") related to any liabilities, claims, or losses on my account caused or alleged to be caused in whole or in part by the Releasees even if arising from the negligence of the Releasees. I have read this release of liability and assumption of risk provision, fully understand its terms, acknowledge that I have given up substantial rights by signing it, and sign it freely and voluntarily without any inducement. I further agree that if, despite this release, I, or anyone on my behalf, makes a claim against any of the Releasees, I will indemnify and hold harmless each of the Releasees from any such liabilities, claims, or losses as the result of such claim. I agree that if any part of this form is held to be invalid, the other parts shall continue in full force and effect.**

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 (dd/mm/yyyy): ____/____/____

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 (dd/mm/yyyy): ____/____/____

Printed Name: _____

Relationship: _____

EVALUATION AND RESEARCH (Optional)

Special Olympics wants to help our athletes and their families stay healthy and happy. We may take part in research studies and would share information for your potential participation. All studies will be checked by the Special Olympics Chief Health Officer.

Would you or your family be interested in learning about research studies?

Yes

No



EMERGENCY MEDICAL CARE REFUSAL FORM

Instructions: Only complete this Emergency Medical Refusal Form (this "Form") if you do not consent to emergency medical care on religious or other grounds and have marked a box under the Emergency Care provision on the Special Olympics Athlete Registration Form ("Athlete Registration Form").

I am a Special Olympics Athlete with the capacity to sign legal documents on my own behalf and agree to the following; or I am the Parent/Guardian of the Athlete named below who is a minor or lacks the capacity to sign legal documents and agree to the following on their behalf.

1. **No Consent to Emergency Medical Care.** I understand that the Athlete Registration form requires Athletes or their Parents/Guardians to consent to emergency medical care for an Athlete if needed in an emergency. Based on my religious beliefs and/or other reasons **I DO NOT CONSENT** to emergency medical care in an emergency.

YOU MUST MARK THE BOX AND WRITE YOUR INITIALS NEXT TO ONE STATEMENT TO CONFIRM YOUR INTENT TO NOT CONSENT TO EMERGENCY MEDICAL CARE:

- ☐ I DO NOT CONSENT TO ANY KIND OF EMERGENCY MEDICAL CARE, EVEN IN A LIFE-THREATENING EMERGENCY. **INITIALS:** _____
- ☐ I DO NOT CONSENT TO BLOOD TRANSFUSIONS, EVEN IN A LIFE-THREATENING EMERGENCY. I CONSENT TO ALL OTHER KINDS OF EMERGENCY MEDICAL CARE. **INITIALS:** _____

2. **Assumption of Risk; Waiver and Release of Liability; Indemnification.** I understand the risks involved with participating in Special Olympics activities and fully accept and assume all risks and all responsibility for losses, costs, and damages I may incur as a result of my participation. By marking one or more of the boxes and adding my initials in Section 1 above, to the fullest extent of the law, I release and agree not to sue SOI, any Special Olympics Program (a "Program" or "Programs"), Local Organizing Committee or other Special Olympics organization, or their directors, agents, volunteers, and employees, other participants, sponsoring agencies, sponsors, advertisers, and, if applicable, owners and lessors of premises (collectively, the "Releasees") for any claims that may arise out of taking or failing to take measures to provide me with emergency medical care even if arising from the negligence of the Releasees. I am agreeing to this release, and acknowledge I have given up substantial rights, because I have refused, knowingly and voluntarily, without inducement, to give the Releasees permission to take emergency measures, and I am expressly withholding consent to emergency medical care on religious or other grounds. I further agree that if, despite this release, I or anyone on my behalf, makes a claim against any of the Releasees, I will indemnify and hold harmless each of the Releasees from any such liabilities, claims, or losses resulting from that claim. I agree that if any part of this Form is held to be invalid, the remaining parts shall continue in full force and effect.

3. **Printed Instructions.** I agree to carry printed instructions that describe my religious or other objections to emergency medical care as described in this Form and how I wish the person accompanying me to respond if I get sick or hurt and cannot speak for myself. I agree to carry these printed instructions with me at all times during my participation in any Special Olympics activity, including during mealtimes, in overnight accommodations, at training sessions and competitions, and during travel to and from Special Olympics activities.

4. **Parent or Guardian Accompaniment.** I understand that I must be accompanied by a Parent/Guardian in order for that person to take personal responsibility for me during a medical emergency in which I am unable to speak for myself.
5. **Emergency Medical Care If Athlete Is Not Accompanied.** I understand that if I am not carrying the printed instructions or the accompanying Parent/Guardian is not present and actively taking personal responsibility for me during a medical emergency where I am unable to speak for myself, Special Olympics may seek emergency medical care for me as recommended by medical professionals responding to the emergency. I waive any claims against the Releasees should they seek emergency care for me.

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 (dd/mm/yyyy): ____/____/____

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 (dd/mm/yyyy): ____/____/____

Printed Name: _____

Relationship: _____

Athlete Medical Form

Special Olympics



To be completed by a Licensed Medical Practitioner qualified to conduct physical exams and prescribe medications. If necessary, please use additional pages to list anything else Special Olympics should know about this athlete.

Athlete first and last name: _____

Date of birth (dd/mm/yyyy): ____/____/____

Height (in/cm)	Weight (lb/kg)	Waist Circumference (in/cm)	Temperature (°F/°C)	Pulse (bpm)	O2Sat (%)	Blood Pressure (mmHG)		Vision (out of 20)	
						systolic	diastolic	os	od

Does the athlete present with any of the following?						
High Blood Pressure	Yes	No		Coeliac Disease	Yes	No Unknown
Kidney Disease	Yes	No	Unknown	Osteoporosis	Yes	No Unknown
Anemia	Yes	No	Unknown	Non-verbal	Yes	No

Has any family member or relative died of heart problems or of sudden death before age 50?	Yes	No
Was the athlete born without or missing a kidney, an eye, a testicle, or any other organ?	Yes	No

Does the athlete have any past surgeries?	Yes	No	Unknown
Did the athlete ever have an abnormal Electrocardiogram (EKG) or Echocardiogram (ECHO)?	Yes	No	Unknown
Did the athlete ever have any broken bones or dislocated joints?	Yes	No	Unknown
Does the athlete have liver disease?	Yes	No	Unknown
Does the athlete have lung disease?	Yes	No	Unknown
Does the athlete have heart disease?	Yes	No	Unknown

Medical		
Eyes, ears, nose, and throat: include pupils, hearing	Normal	Abnormal
Heart: Include murmurs (auscultation standing, auscultation supine, and ± valsalva maneuver)	Normal	Abnormal
Lungs	Normal	Abnormal
Abdomen	Normal	Abnormal
Skin: HSV, MRSA, or tinea corporis	Normal	Abnormal
Neurological	Normal	Abnormal

Musculoskeletal					
Neck	Normal	Abnormal	Hip and thigh	Normal	Abnormal
Back	Normal	Abnormal	Knee	Normal	Abnormal
Shoulder and arm	Normal	Abnormal	Lower leg and ankle	Normal	Abnormal
Elbow and forearm	Normal	Abnormal	Foot and toes	Normal	Abnormal
Wrist, hand, and fingers	Normal	Abnormal			

Additional findings for any of the above conditions:

Medical Physical Examination - To be completed by practitioner only.

MEDICAL ELIGIBILITY FOR SPORT (TO BE COMPLETED BY PRACTITIONER ONLY)

Licensed Medical Practitioner: It is recommended that the practitioner review items on the medical history with the athlete or their guardian, prior to performing the physical exam. If further medical evaluation is warranted, the practitioner must refer the athlete to a specialist and reassess the results from this examination to determine eligibility for participation.

Medically eligible for all sports or for sports listed: _____ without restriction.

Medically eligible for all sports or for sports listed: _____

with recommendations for further evaluation or treatment of: _____

Not medically eligible pending further evaluation of: _____

Not medically eligible to participate in the following sports: _____

Not medically eligible for any sports

I have examined the athlete named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of licensed medical practitioner (print or type): _____

Date (dd/mm/yyyy): ____/____/____

Address: _____

Phone: _____

Signature of licensed medical practitioner: _____

NPI or License number: _____

License type (MD, DO, NP, or PA): _____



2026 Program Year – Registration Dates

**Dates are subject to change depending on changes sent from Special Olympics Ohio*

Spring Season –

Powerlifting: March 2nd—May 31st **Registration Deadline: February 18, 2026**

Practice Location: Social Stacked Club (78 W. Water St, Chillicothe)

Athletics (Track & Field): March 16th—May 31st **Registration Deadline: March 4, 2026**

Practice Location: CHS Herrnstein Field/Bobo Track (401 Stacey Rd, Chillicothe)

Bowling: March 30th—May 31st **Registration Deadline: March 11, 2026**

Practice Location: Shawnee Lanes

Summer/Fall Season –

Golf: July—September **Registration Deadline: June 3, 2026**

Practice Location: Jaycee Golf Course (12100 Pleasant Valley Rd, Chillicothe)

Cornhole: August—September **Registration Deadline: July 22, 2026**

Practice Location: Pioneer School Track (11268 Co Rd 550, Chillicothe)

Flag Football: August—October **Registration Deadline: July 22, 2026**

Practice Location: Chillicothe Park Annex (Borlands Xing, Chillicothe)

Disc Golf: August—September: **Registration Deadline: July 22, 2026**

Practice Location: Aileen Cole Stewart Memorial DGC (17273 OH-104, Chillicothe)

Winter Season – Registration Deadline: September 2, 2026

Basketball: October—February

Practice Location: OUC Shoemaker Center (101 University Drive, Chillicothe)

Cheerleading: October—December

Practice Location: Pioneer Center (167 W. Main Street, Chillicothe)

Swimming: October—February

Practice Location: YMCA of Ross County (100 Mill St, Chillicothe)