

ATHLETE APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS MARYLAND (valid for 3 years)

COUNTY _____ SOC. SEC # _____ DOB ____/____/____

FEMALE or MALE ATHLETE or PARTNER NEW ATHLETE or CURRENT

ATHLETE INFORMATION

NAME _____
 ADDRESS _____
 CITY/STATE/ZIP _____
 HOME PHONE (____) _____ FAX (____) _____
 CELL PHONE (____) _____
 E-MAIL _____
 HEALTH/ACCIDENT INSURANCE CO _____
 POLICY # _____

ETHNICITIES (OPTIONAL) CHECK ALL THAT APPLY:
 CAUCASIAN ASIAN AMERICAN AFRICAN AMERICAN
 MEXICAN CARIBBEAN HISPANIC OTHER

SCHOOL / AGENCY / EMPLOYER

NAME _____
 ADDRESS _____
 CITY/STATE/ZIP _____
 PHONE (____) _____ FAX (____) _____

PARENT / GUARDIAN INFORMATION

NAME _____
 ADDRESS _____
 CITY/STATE/ZIP _____
 HOME PHONE (____) _____ FAX (____) _____
 CELL PHONE (____) _____
 E-MAIL _____

EMPLOYER

NAME _____
 ADDRESS _____
 CITY/STATE/ZIP _____
 PHONE (____) _____ FAX (____) _____

EMERGENCY CONTACT (IF OTHER THAN PARENT)

NAME _____
 PHONE (____) _____
 CELL PHONE (____) _____

HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER:

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	*HEART DISEASE / HEART DEFECT / HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	HEAT STROKE / EXHAUSTION
<input type="checkbox"/>	<input type="checkbox"/>	*CHEST PAIN	<input type="checkbox"/>	<input type="checkbox"/>	FALSE TEETH / DENTURES
<input type="checkbox"/>	<input type="checkbox"/>	*SEIZURES / EPILEPSY / FAINTING SPELLS	<input type="checkbox"/>	<input type="checkbox"/>	TOBACCO USE
<input type="checkbox"/>	<input type="checkbox"/>	*DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	EASY BLEEDING
<input type="checkbox"/>	<input type="checkbox"/>	*CONCUSSION OR SERIOUS HEAD INJURY	<input type="checkbox"/>	<input type="checkbox"/>	HEARING LOSS / SEVERE HEARING PROBLEM / HEARING AID
<input type="checkbox"/>	<input type="checkbox"/>	*MAJOR SURGERY OR SERIOUS ILLNESS	<input type="checkbox"/>	<input type="checkbox"/>	CONTACT LENSES / GLASSES
<input type="checkbox"/>	<input type="checkbox"/>	*BLINDNESS / SEVERE VISUAL PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>	OTHER HEALTH ISSUES
<input type="checkbox"/>	<input type="checkbox"/>	*ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	SPECIAL DIET (specify)
<input type="checkbox"/>	<input type="checkbox"/>	SICKLE CELL TRAIT OR DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGY TO MEDICINES (specify)
<input type="checkbox"/>	<input type="checkbox"/>	BONE OR JOINT PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGY TO FOOD (specify)
<input type="checkbox"/>	<input type="checkbox"/>	MISSING ONE KIDNEY	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGY TO INSECT STING / BITE (specify)
<input type="checkbox"/>	<input type="checkbox"/>	EMOTIONAL / PSYCHIATRIC / BEHAVIORAL PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>	DATE OF LAST TETANUS SHOT
<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS	ARE IMMUNIZATIONS UP TO DATE		YES <input type="checkbox"/> NO <input type="checkbox"/>

HAS ATHLETE EVER BEEN CHARGED / CONVICTED OF A CRIMINAL OFFENSE? YES NO
 HAS ATHLETE EVER BEEN CHARGED WITH ABUSE OF ASSAULT? YES NO
 DOES ATHLETE HAVE ANY PENDING CRIMINAL CASES? YES NO
 IS ATHLETE NOW ON PROBATION FOR ANY CRIMINAL OR TRAFFIC VIOLATION? YES NO
 HAS ATHLETE EVER BEEN FOUND "NOT CRIMINALLY RESPONSIBLE" FOR ANY CRIMINAL OR TRAFFIC OFFENSE? YES NO

ANSWERING 'YES' TO ANY OF THE ABOVE QUESTIONS DOES NOT EXCLUDE APPLICANT FROM PARTICIPATION IN SPECIAL OLYMPICS MARYLAND ACTIVITIES

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE EXPLAIN THE DATES AND DETAILS OF EACH CASE ON A SEPARATE SHEET OF PAPER & ATTACH TO THIS FORM

MEDICATIONS

NAME OF MEDICATION	DOSAGE (MM)	TIMES PER DAY	DATE OF PRESCRIPTION

SIGNATURE – PLEASE SIGN BELOW TO INDICATE THAT ALL OF THE ABOVE INFORMATION IS CORRECT, ACCURATE AND UP-TO-DATE

SIGNATURE OF PARENT/GUARDIAN/ADULT ATHLETE _____ DATE ____/____/____

PHYSICAL EXAMINATION

ATHLETE NAME _____
 BLOOD PRESSURE _____ HEIGHT _____ft _____inches WEIGHT _____lbs
 PRIMARY ID ETIOLOGY/CATEGORY _____ IF PREGNANT, DUE DATE ____/____/____

NORMAL	ABNORMAL	NORMAL	ABNORMAL	NORMAL	ABNORMAL	NORMAL	ABNORMAL
<input type="checkbox"/>	<input type="checkbox"/> VISION	<input type="checkbox"/>	<input type="checkbox"/> GARDIOVASCULAR SYSTEM	<input type="checkbox"/>	<input type="checkbox"/> RESPIRATORY SYSTEM	<input type="checkbox"/>	<input type="checkbox"/> NECK
<input type="checkbox"/>	<input type="checkbox"/> HEARING	<input type="checkbox"/>	<input type="checkbox"/> GENITO-URINARY SYSTEM	<input type="checkbox"/>	<input type="checkbox"/> CRANIAL NERVES	<input type="checkbox"/>	<input type="checkbox"/> SKIN
<input type="checkbox"/>	<input type="checkbox"/> ORAL CAVITY	<input type="checkbox"/>	<input type="checkbox"/> GASTROINTESTINAL SYSTEM	<input type="checkbox"/>	<input type="checkbox"/> COORDINATION	<input type="checkbox"/>	<input type="checkbox"/> REFLEXES
<input type="checkbox"/>	<input type="checkbox"/> EXTREMITIES						

COMMENTS _____

RESTRICTIONS _____

SIGN

APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS MARYLAND / SIDE TWO

I AM A LICENSED MEDICAL PROFESSIONAL. I HAVE REVIEWED THE ACCOMPANYING HEALTH INFORMATION AND HAVE PERFORMED THE ABOVE EXAMINATION ON THIS ATHLETE WITHIN THE LAST 6 MONTHS AND CERTIFY THAT THE ATHLETE CAN PARTICIPATE IN SPECIAL OLYMPICS.

EXAMINER'S NAME (Print or use Stamp) _____ PHONE (____) _____

ADDRESS _____

CITY/STATE/ZIP _____

EXAMINER'S SIGNATURE _____ DATE ____/____/____

FOR ATHLETES WITH DOWN SYNDROME:

PERSONS WITH DOWN SYNDROME MUST HAVE A LATERAL X-RAY OF THE CERVICAL SPINE IN HYPERFLEXION AND HYPEREXTENSION. THE INTERPRETATION OF THE RADIOGRAPHS MUST INCLUDE MEASUREMENTS OF THE ATLANTO-DENS INTERVAL.

YES NO YES NO
 HAS AN X-RAY EVALUATION FOR ATLANTOAXIAL INSTABILITY BEEN DONE? IF YES, WAS THE ATLANTO-DENS INTERVAL 5MM OR MORE?

OFFICIAL SPECIAL OLYMPICS RELEASE FORM

I, _____, am at least 18 years old and have submitted this application for participation in Special Olympics.

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 to my neck or upper spine unless I have a full radiological examination which established the absence of Atlanto-axial instability. I am aware that I must have this radiological examination before I can participate in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing and soccer.

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 those 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 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 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 the provisions of this release.

Name (print) _____ Relationship to athlete _____

I am the parent/guardian of _____, the minor athlete, on whose behalf I have submitted this application for participation in Special Olympics. I hereby represent that the athlete has my permission to participate in Special Olympics activities.

I further represent and warrant that, to the best of my knowledge and belief, the athlete is physically and mentally able to participate in Special Olympics. With my approval, a licensed physician has reviewed the health information set forth in the athlete's application and has certified based on an independent medical examination, that there is no medical evidence which would preclude the athlete's participation. I understand that if the athlete has Down syndrome, he/she cannot participate in sports or events which by their nature result in hyper-extension, radical flexion or direct pressure to the neck or upper spine unless the athlete has a full radiological examination which establishes the absence of Atlanto-axial instability. I am aware that the sports events for which this radiological examination is required are equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing and soccer.

In permitting the athlete to participate, I am specifically granting my permission, (both during and anytime after) to special Olympics to use the athlete's 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 those purposes and activities.

If a medical emergency should arise during the athlete's participation in any Special Olympics activities, at a time when I am not personally present so as to be consulted regarding the athlete's care, I hereby authorize Special Olympics to take whatever measures are necessary to ensure that the athlete is provided with any emergency medical treatment, including hospitalization, which Special Olympics deems advisable in order to protect the athlete's health and well-being.

I am the parent/guardian of the athlete named in this application. I have read and fully understand the provisions of the above release, and have explained these provisions to the athlete. Through my signature on this release form, I am agreeing to the above provisions on my own behalf and on the behalf of the athlete named herein.

I hereby give my permission for the athlete named above to participate in Special Olympics Games, recreation programs and physical activity programs.

Signature of Parent/Guardian _____ Date ____/____/____

Name (print) _____

SPECIAL OLYMPICS MARYLAND HOUSING POLICY

The health and safety of all Special Olympics Maryland participants is of paramount importance to Special Olympics Maryland. Athletes should feel that every Special Olympics Maryland event is a safe and positive experience and should not be fearful of other athletes, coaches or volunteers. Athletes will be matched for housing based on size, level of maturity, ability and age. Each member of the delegation shall be assigned his/her own bed. Athletes and volunteers may not share a room with an athlete or volunteer of the opposite sex*. The chaperone/athlete ratio of at least one properly registered chaperone to every four athletes must be maintained during overnight events. All chaperones must be screened in accordance with the Special Olympics Volunteer Screening Policy.

*See complete Special Olympics Maryland Housing Policy for allowed exceptions.

The complete Special Olympics Maryland Housing Policy can be found at <http://www.somd.org/pdfs/ATHLETE%20Housing%20Policy%202012-.pdf>

By signing below I acknowledge that I have read and accept the Special Olympics Maryland Housing Policy and will abide by the terms of the policy.

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 the provisions of this release.

Name (print) _____ Relationship to athlete _____

IF ATHLETE IS A MINOR:

Signature of Parent/Guardian _____ Date ____/____/____

Name (print) _____

INFORMATION ON CONCUSSIONS

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly.** In other words, even a "ding" or a bump on the head can be serious. You can't see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If you/your athlete report any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away. Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that athletes will often under report symptoms of injuries, and concussions are no different. As a result, education of administrators, coaches, parents and athletes is the key for athlete safety. Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without medical clearance. Close observation of the athlete should continue for several hours. Special Olympics Maryland, Inc. requires the consistent and uniform implementation of well-established return to play concussion guidelines that have been recommended for several years including an athlete who is suspected of sustaining a concussion or head injury in a practice or game shall be removed from competition at that time and may not return to play until the athlete is evaluated by a licensed health care provider trained in the evaluation and management of concussion and has received written clearance to return to play from that health care provider. For a listing of potential symptoms, view the complete Concussion Information Sheet at <http://www.somd.org/resources/sports/concussioninformation.html>. For current and up-to-date information on concussions you can go to: <http://www.cdc.gov/Concussion>

Signature of adult athlete _____ Date ____/____/____

I hereby certify that I have reviewed this information with the athlete whose signature appears above. I am satisfied based on that review that the athlete understands this release and has agreed to the provisions included.

Name (print) _____ Relationship to athlete _____

IF ATHLETE IS A MINOR:

Signature of Parent/Guardian _____ Date ____/____/____

Name (print) _____