



Special Olympics Arizona-Field Service Operations  
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**MEDICAL/PARENTAL RELEASE FORM**

**PROGRAM NAME:** \_\_\_\_\_

**AREA #:** \_\_\_\_\_ **PROGRAM #:** \_\_\_\_\_

**DEMOGRAPHICS**

Athlete's First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_

Gender: Male  Female

Athlete's Date of Birth: (M/D/Y) \_\_\_\_/\_\_\_\_/\_\_\_\_ Athlete's Email Address: \_\_\_\_\_

Athlete's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Athlete's Home Phone #: (\_\_\_\_) \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_

Parent/Guardian's Address (If different than above): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent Primary Phone #: (\_\_\_\_) \_\_\_\_\_ Parent Email Address: \_\_\_\_\_

Emergency Contact Name (if other than parent/guardian): \_\_\_\_\_

Emergency Contact Phone #: (\_\_\_\_) \_\_\_\_\_

Health/Accident Insurance Co: \_\_\_\_\_ Policy #: \_\_\_\_\_

**HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER/ADULT ATHLETE**

- |  |                          |                                  |                          |                              |                          |
|--|--------------------------|----------------------------------|--------------------------|------------------------------|--------------------------|
| <b>Yes</b>                                     | <b>No</b>                | <b>Yes</b>                       | <b>No</b>                | <b>Yes</b>                   | <b>No</b>                |
| <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/>     | <input type="checkbox"/> |
| Heart Disease/Heart Defect/High Blood Pressure |                          | Requires Extra Supervision       |                          | Tobacco Use                  |                          |
| <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/>     | <input type="checkbox"/> |
| Diabetes                                       |                          | Deaf                             |                          | Heat Stroke/Exhaustion       |                          |
| <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/>     | <input type="checkbox"/> |
| Seizures/Epilepsy                              |                          | Hearing Loss/Hearing Aid         |                          | Shunts                       |                          |
| <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/>     | <input type="checkbox"/> |
| Asthma   |                          | Hepatitis                        |                          | Chest Pain                   |                          |
| <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/>     | <input type="checkbox"/> |
| Blind  |                          | Concussion/Head injury           |                          | Easy Bleeding                |                          |
| <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/>     | <input type="checkbox"/> |
| Visually Impaired                              |                          | Major Surgery/Serious Illness    |                          | Bone or Joint Problem        |                          |
| <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/>     | <input type="checkbox"/> |
| Contact Lenses/Glasses                         |                          | Immunizations up to Date         |                          | Sickle Cell Trait or Disease |                          |
| <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> | <input type="checkbox"/>     | <input type="checkbox"/> |
| Allergies: Insect Stings/Bites: _____          |                          | Fainting Spells                  |                          | Special Diet _____           |                          |
| <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/>         | <input type="checkbox"/> |                              |                          |
| Allergies: Food: _____                         |                          | Emotional/Psychiatric/Behavioral |                          |                              |                          |
| <input type="checkbox"/>                       | <input type="checkbox"/> |                                  |                          |                              |                          |
| Allergies: Medicines: _____                    |                          | Other _____                      |                          |                              |                          |

Date of most recent Tetanus Immunization: \_\_\_\_/\_\_\_\_/\_\_\_\_

MEDICATIONS: Please print medication name, amount, date prescribed and number of times per day given. All changes in medication should be submitted to Special Olympics Arizona. For more space, attach additional paper.

Medication Name	Dosage	Date Prescribed	Times Per Day

Signature of parent/caregiver/adult athlete: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PHYSICAL EXAMINATION: TO BE COMPLETED BY MEDICAL EXAMINER**

Blood Pressure: \_\_\_\_/\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

- |   |   |  |   |
|---|---|--|---|
| <b>Normal/Abnormal</b>  | <b>Normal/Abnormal</b>  | <b>Normal/Abnormal</b>   | <b>Normal/Abnormal</b>  |
| <input type="checkbox"/> <input type="checkbox"/> Vision      | <input type="checkbox"/> <input type="checkbox"/> Cardiovascular System   | <input type="checkbox"/> <input type="checkbox"/> Cranial Nerves       | <input type="checkbox"/> <input type="checkbox"/> Skin        |
| <input type="checkbox"/> <input type="checkbox"/> Hearing     | <input type="checkbox"/> <input type="checkbox"/> Respiratory System      | <input type="checkbox"/> <input type="checkbox"/> Genitourinary System | <input type="checkbox"/> <input type="checkbox"/> Neck        |
| <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    |
| Other: _____  |   |  | <input type="checkbox"/> <input type="checkbox"/> Extremities |

Primary MR: \_\_\_\_\_

**ATLANTO-AXIAL INSTABILITY ASSESSMENT FOR ATHLETES WITH DOWN SYNDROME**

Examiner's Note: If the athlete has Down Syndrome, Special Olympics requires a full radiological examination establishing the absence of Atlanto-axial Instability before he/she may participate in sports or events which, by their nature, may result in hypertension, radical flexion or direct pressure on the neck or upper spine. The sports and events for which such a radiological examination is required are: judo, equestrian sports, gymnastics, diving, pentathlon, butterfly stroke and diving starts in swimming, high jump, alpine skiing, snowboarding, squat lift, and football team competition (soccer). **PLEASE CIRCLE THE FOLLOWING:** Does the athlete have Down Syndrome? **Yes No**

If yes, has an x-ray for Atlanto-axial instability been done? **Yes No** (If no, the athlete will be restricted from above sports/events.)

**X-Ray Date:** \_\_\_\_\_ If yes, was it positive for Atlanto-axial instability? (the Atlanto-dens interval is 5mm or more) **Yes No** If yes, the athlete will be restricted from above sports/events unless the "Special Release for Athletes with Atlanto-Axial Instability" form is completed.

**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: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**This form is valid for 3 years unless otherwise stated.** Optional expiration date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**REV: 11.06**

# OFFICIAL SPECIAL OLYMPICS ARIZONA RELEASE FORM

Medical/Parental Release Form – pg.2  
(PLEASE PRINT)

## RELEASE TO BE COMPLETED BY ADULT ATHLETE

I, \_\_\_\_\_ (athlete's name) am at least 18 years old and have submitted the attached 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 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 presence of Atlanto-axial Instability, I must have the radiological examination before I can participate in judo, equestrian sports, gymnastics, diving, pentathlon, butterfly stroke and diving starts in swimming, high jump, alpine skiing, snowboarding, squat lift, and football team competition (soccer). Special Olympics has my permission, (both during and anytime after), to use my likeness, name, voice or words in wither 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 for 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.)

**THIS FORM IS VALID FOR THREE YEARS**

## RELEASE TO BE COMPLETED BY PARENT OR GUARDIAN OF MINOR ATHLETE

I am the parent/guardian of \_\_\_\_\_ (athlete's name), 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 further represent and warrant that to be 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 on the neck or upper spine, unless two physicians and I have completed the official "Special Release for Athletes with Atlanto-Axial Instability." Available from the Special Olympics Chapter program in my state, or the athlete has 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, the athlete must have the radiological examination before he/she can participate in judo, equestrian sports, gymnastics, diving, pentathlon, butterfly stroke and diving starts in swimming, high jump, alpine skiing, snowboarding, squat lift, and football team competition (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 and words in 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 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, on my behalf, 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 above.

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**

**THIS FORM IS VALID FOR THREE YEARS**