APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS RHODE ISLAND

DEMOGRAPHICS

PROGRAM: ____

Athlete's Name ____

Athlete's Address ____

____

City State Zip

Parent/Guardian's Name ____

Parent/Guardian's Address (if different than athlete) ______________________

____

Emergency Contact (if other than parent/guardian) ______________________

Health/Accident Insurance Company ______________________

☐ Male
☐ Female

Date of Birth (month/day/year)
______/______/______

Athlete Home Phone # ______________________

Parent Primary Phone # ______________________

Parent Secondary Phone # ______________________

Primary Phone # ______________________

Policy # ______________________

HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER

Yes	No	
☐	☐	*Heart disease / heart defect / high blood pressure
☐	☐	*Chest pain
☐	☐	*Seizures / epilepsy/fainting spells
☐	☐	*Diabetes
☐	☐	*Concussion or serious head injury
☐	☐	*Major surgery or serious illness
☐	☐	Heat stroke / exhaustion
☐	☐	*Blindness / visual problem
☐	☐	Contact lenses / glasses
☐	☐	Hearing loss / hearing aid
☐	☐	Bone or joint problem

Wheelchair ______ Manual ______ Power

Date of most recent tetanus immunization ______/_____/_____

(*) Requires physical examination

Yes	No	
☐	☐	Allergy:
☐	☐	Medicines: ______________________
☐	☐	Food: ______________________
☐	☐	Insect stings/bites: ______________________
☐	☐	Special diet
☐	☐	*Asthma
☐	☐	Tobacco use
☐	☐	Easy bleeding
☐	☐	emotional / psychiatric / behavioral
☐	☐	Sickle cell trait or disease
☐	☐	Immunizations up to date
☐	☐	Other (for addiotnal space, use back of form) ______________________

Medications:

Please print medication name, amount, date prescribed and number of times per day medication is given.

Medication Name	Dosage	Date Prescribed	Times per day	Medication Name	Dosage	Date Prescribed	Times per day

Signature of parent/caregiver/adult athlete: ______________________ Date _____/_____/_____

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 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: 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).

Yes	No	
☐	☐	Has an x-ray evaluation for atlanto-axial instability been done?
☐	☐	If yes, was it positive for atlanto-axial instability? (positive indicates that the atlanto-dens interval is 5mm or more)

PHYSICAL EXAMINATION

Blood pressure: _____/_____ Weight: _____ Height: _____

Normal	Abnormal	
☐	☐	Vision
☐	☐	Hearing
☐	☐	Oral cavity
☐	☐	Neck
☐	☐	Extremities
☐	☐	Cardiovascular system
☐	☐	Respiratory system
☐	☐	Gastrointestinal system
☐	☐	Genitourinary system
☐	☐	Skin
☐	☐	Cranial nerves
☐	☐	Coordination
☐	☐	Reflexes

Other: ____

Primary MR Etiology/Category (If known): ______________________

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: ______________________

______________________ PHONE: ______________________