ATHLETE REGISTRATION FORM

State Special Olympics Program: ____________________________  Local Area/Delegation: ____________________________

Are you a new athlete to Special Olympics or Re-Registering?  

- New Athlete  
- Re-Registering

### ATHLETE INFORMATION

<table>
<thead>
<tr>
<th>First Name:</th>
<th>Middle Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name:</td>
<td>Preferred Name:</td>
</tr>
<tr>
<td>Date of Birth (mm/dd/yyyy):</td>
<td></td>
</tr>
<tr>
<td>Race/Ethnicity (Optional):</td>
<td></td>
</tr>
</tbody>
</table>
- American Indian/Alaskan Native
- Asian
- Two or More Races
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Hispanic or Latino (specific origin group: ____________________________)

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)

<table>
<thead>
<tr>
<th>Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship:</td>
</tr>
<tr>
<td>Same Contact Info as Athlete</td>
</tr>
</tbody>
</table>

Street Address: ____________________________

City: ____________________________  State:  
Zip Code: ____________________________

Phone: ____________________________  E-mail: ____________________________

### EMERGENCY CONTACT INFORMATION

- Same as Parent/Guardian

<table>
<thead>
<tr>
<th>Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship:</td>
<td></td>
</tr>
</tbody>
</table>

### PHYSICIAN & INSURANCE INFORMATION

Physician Name: ____________________________

Physician Phone: ____________________________

Insurance Company: ____________________________  Insurance Policy Number: ____________________________

Insurance Group Number: ____________________________

A1 Athlete Registration – Updated October 2018
I agree to the following:

1. **Ability to Participate.** I am physically able to take part in Special Olympics activities.

2. **Likeness Release.** I give permission to Special Olympics, Inc., Special Olympics games organizing committees, and Special Olympics accredited Programs (collectively "Special Olympics") to use my likeness, photo, video, name, voice, words, and biographical information to promote Special Olympics and raise funds for Special Olympics.

3. **Risk of Concussion and Other Injury.** I know there is a risk of injury. I understand the risk of continuing to play sports with or after a concussion or other injury. I may have to get medical care if I have a suspected concussion or other injury. I also may have to wait 7 days or more and get permission from a doctor before I start playing sports again.

4. **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. (Not common.)
   - [ ] I do not consent to blood transfusions. (Not common.)
   (If either box is marked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)

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

6. **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 can say no to treatment or anything else at any time.

7. **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.
     - 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](http://www.SpecialOlympics.org/Privacy-Policy).

<table>
<thead>
<tr>
<th>Athlete Name:</th>
</tr>
</thead>
</table>

**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.

<table>
<thead>
<tr>
<th>Athlete Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

**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.

<table>
<thead>
<tr>
<th>Parent/Guardian Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

**Printed Name:**

<table>
<thead>
<tr>
<th>Printed Name:</th>
<th>Relationship:</th>
</tr>
</thead>
</table>
Athlete Medical Form – HEALTH HISTORY
(To be completed by the athlete or parent/guardian/caregiver and brought to exam)

Special
Olympics

Athlete First & Last Name: ___________________________ Preferred Name: ________________________

Female □ Male □

Athlete Date of Birth (mm/dd/yyyy): ____________________________

STATE PROGRAM: ____________________________ E-mail: ____________________________

ASSOCIATED CONDITIONS - Does the athlete have (check any that apply):

□ Autism □ Down Syndrome □ Fragile X Syndrome

□ Cerebral Palsy □ Fetal Alcohol Syndrome

□ Other Syndrome, please specify:

ASSISTIVE DEVICES - 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

List any special dietary needs:

SPORTS PARTICIPATION

List all Special Olympics sports the athlete wishes to play:

Has a doctor ever limited the athlete’s participation in sports?
□ No □ Yes

If yes, please describe:

SURGERIES, INFECTIONS, VACCINES

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 Echocardiogram (Echo)? If yes, describe date and results
□ Yes, had abnormal EKG

□ Yes, had abnormal Echo

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

EPILEPSY AND/OR SEIZURE HISTORY

Epilepsy or any type of seizure disorder
□ No □ Yes

If yes, list seizure type:

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

MENTAL HEALTH

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

Depression (diagnosed) □ No □ Yes

Aggressive behavior during the past year
□ No □ Yes

Anxiety (diagnosed) □ No □ Yes

Describe any additional mental health concerns:

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’s First and Last Name: ____________________________

HAS THE ATHLETE EVER BEEN DIAGNOSED WITH OR EXPERIENCED ANY OF THE FOLLOWING CONDITIONS

<table>
<thead>
<tr>
<th>Condition</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of Consciousness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dizziness during or after exercise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headache during or after exercise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest pain during or after exercise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shortness of breath during or after exercise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Irregular, racing or skipped heart beats</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Congenital Heart Defect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Attack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiomyopathy</td>
<td></td>
<td></td>
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<tr>
<td>Heart Valve Disease</td>
<td></td>
<td></td>
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<tr>
<td>Heart Murmur</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endocarditis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Vision Impairment</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Hearing Impairment</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Enlarged Spleen</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Single Kidney</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Osteopenia</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Sickle Cell Disease</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Sickle Cell Trait</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Easy Bleeding</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
| If female athlete, list date of last menstrual period: ________________________________________

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

List any other ongoing or past medical conditions:

<table>
<thead>
<tr>
<th>Neurological Symptoms for Spinal Cord Compression and Atlanto-axial Instability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty controlling bowels or bladder</td>
</tr>
<tr>
<td>Numbness or tingling in legs, arms, hands or feet</td>
</tr>
<tr>
<td>Weakness in legs, arms, hands or feet</td>
</tr>
<tr>
<td>Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet</td>
</tr>
<tr>
<td>Head Tilt</td>
</tr>
<tr>
<td>Spasticity</td>
</tr>
<tr>
<td>Paralysis</td>
</tr>
</tbody>
</table>

If yes, is this new or worse in the past 3 years?

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

<table>
<thead>
<tr>
<th>Medication, Vitamin or Supplement Name</th>
<th>Dosage</th>
<th>Times per Day</th>
<th>Medication, Vitamin or Supplement Name</th>
<th>Dosage</th>
<th>Times per Day</th>
<th>Medication, Vitamin or Supplement Name</th>
<th>Dosage</th>
<th>Times per Day</th>
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</tbody>
</table>

Is the athlete able to administer his or her own medications? No Yes

Name of Person Completing this Form: ____________________________
Relationship to Athlete: ____________________________
Phone: ____________________________ Email: ____________________________
**Athlete Medical Form – PHYSICAL EXAM**  
(To be completed by a Licensed Medical Professional qualified to conduct exams & prescribe medications)

Athlete’s First and Last Name: ________________________________

---

**MEDICAL PHYSICAL INFORMATION**  
(To be completed by a Licensed Medical Professional qualified to conduct physical exams and prescribe medications)

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>BMI (optional)</th>
<th>Temperature</th>
<th>Pulse</th>
<th>O2 Sat</th>
<th>Blood Pressure (in mmHg)</th>
<th>Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>cm</td>
<td>kg</td>
<td></td>
<td>C</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>in</td>
<td>lbs</td>
<td>Body Fat %</td>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- 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

---

**SPINAL CORD COMPRESSION & ATLANTO-AXIAL INSTABILITY (AAI) (Select one)**

- [ ] Athlete shows NO EVIDENCE of neurological symptoms or physical findings associated with spinal cord compression or atlanto-axial instability.
- [ ] Athlete has neurological symptoms or physical findings that could be associated with spinal cord compression or atlanto-axial instability and must receive an additional neurological evaluation to rule out additional risk of spinal cord injury prior to clearance for sports participation.

---

**ATHLETE CLEARANCE TO PARTICIPATE (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 needs further medical evaluation please make a referral below and second physician for referral should complete page 4.

- [ ] This athlete is ABLE to participate in Special Olympics sports without restrictions.
- [ ] This athlete is ABLE to participate in Special Olympics sports WITH restrictions. Describe:

  ____________________________

- [ ] This athlete MAY NOT participate in Special Olympics sports at this time & MUST be further evaluated by a physician for the following concerns:
  - [ ] Concerning Cardiac Exam
  - [ ] Concerning Neurological Exam
  - [ ] Other, please describe:
  - [ ] Acute Infection
  - [ ] Stage II Hypertension or Greater
  - [ ] O2 Saturation Less than 90% on Room Air
  - [ ] Hepatomegaly or Splenomegaly
  - [ ] Other, please describe:

**Additional Licensed Examiner’s Notes and Recommended (but not required) Follow-up:**

- [ ] Follow up with a cardiologist
- [ ] Follow up with a vision specialist
- [ ] Follow up with a podiatrist
- [ ] Follow up with a neurologist
- [ ] Follow up with a hearing specialist
- [ ] Follow up with a physical therapist
- [ ] Follow up with a primary care physician
- [ ] Follow up with a dentist or dental hygienist
- [ ] Follow up with a nutritionist

---

**Signature of Licensed Medical Examiner**  
Exam Date: _________  
Phone: _________  
License #: _________

Name: ____________________________  
E-mail: ____________________________  
Special Olympics Medical Form | 3 of 4

Medical Form for US Programs – updated July 2017
Athlete’s First and Last Name: ________________________________

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

Examiner’s Name: __________________________________________

Specialty: ________________________________________________

I have been asked to perform an additional athlete exam for the following medical concern(s) - Please describe:

☐ Concerning Cardiac Exam    ☐ Acute Infection    ☐ O₂ Saturation Less than 90% on Room Air
☐ Concerning Neurological Exam ☐ Stage II Hypertension or Greater ☐ Hepatomegaly or Splenomegaly
☐ Other, please describe:

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

☐ Yes    ☐ Yes, but with restrictions (list below)    ☐ 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
Educational Material for Parents/Legal Guardians and Athletes
(Content Meets MDH Requirements)
Sources: Michigan Department of Community Health. CDC and the National Operating Committee on Standards for Athletic Equipment (NOCSAE)

UNDERSTANDING CONCUSSION

<table>
<thead>
<tr>
<th>Headache</th>
<th>Pressure in the Head</th>
<th>Nausea/Vomiting</th>
<th>Dizziness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance Problems</td>
<td>Double Vision</td>
<td>Blurry/Vision</td>
<td>Sensitive to Light</td>
</tr>
<tr>
<td>Sensitivity to Noise</td>
<td>Sluggishness</td>
<td>Haziness</td>
<td>Fogginess</td>
</tr>
<tr>
<td>Poor Concentration</td>
<td>Memory Problems</td>
<td>Confusion</td>
<td>“Feeling Down”</td>
</tr>
<tr>
<td>Not “Feeling Right”</td>
<td>Feeling Irritable</td>
<td>Slow Reaction Time</td>
<td>Sleep Problems Grogginess</td>
</tr>
</tbody>
</table>

WHAT IS A CONCUSSION?

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a fall, bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. A concussion can be caused by a shaking, spinning or a sudden stopping and starting of the head. Even a “ding,” “getting your bell rung,” or what seems to be a mild bump or blow to the head can be serious. A concussion can happen even if you haven’t knocked out.

You can’t see a concussion. Signs and symptoms of concussions can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If the athlete reports any symptoms of a concussion, or if you notice symptoms yourself, seek medical attention right away. An athlete who may have had a concussion should not return to play on the day of the injury and until a health care professional says they are okay to return to play.

IF YOU SUSPECT A CONCUSSION:

1. SEEK MEDICAL ATTENTION RIGHT AWAY - A health care professional will be able to decide how serious the concussion is and when it is safe for the athlete to return to regular activities, including sports. Don’t hide it, report it. Ignoring symptoms and trying to “tough it out” often makes it worse.

2. KEEPING YOUR ATHLETE OUT OF PLAY - Concussions take time to heal. Don’t let the athlete return to play the day of injury and until a health care professional says it’s okay. An athlete who returns to play too soon, while the brain is still healing, risks a greater chance of having a second concussion. Young children and teens are more likely to get a concussion and take longer to recover than adults. Repeat or second concussions increase the time it takes to recover and can be very serious. They can cause permanent brain damage, affecting the athlete for lifetime. They can be fatal. It is better to miss one game than the whole season.

3. TELL THE COACH ABOUT ANY PREVIOUS CONCUSSION - Coaches should know if an athlete had a previous concussion. An athlete’s coach may not know about a concussion received in another sport or activity unless you notify them.

SIGNS OBSERVED BY PARENTS/LEGAL GUARDIANS:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Can’t recall events prior to or after a hit
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood or behavior, or personality changes

CONCUSSION DANGER SIGNS:

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. An athlete should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awaken
- A headache that gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people/places
- Becomes increasingly confused
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously.)

HOW TO RESPOND TO A REPORT OF A CONCUSSION:

If an athlete reports one or more symptoms of a concussion after a bump, blow, or jolt to the head or body, s/he should be kept out of athletic play the day of the injury. The athlete should only return to play with permission from a health care professional experienced in evaluating for concussion. During recovery, rest is key. Exercising or activities that involve a lot of concentration (such as studying, working on the computer, or playing video games) may cause concussion symptoms to reappear or get worse. Athletes who return to sports after a concussion may need to take rests breaks and be given extra help and time. After a concussion, returning to sports is a gradual process that should be monitored by a health care professional. If a concussion is diagnosed you must have a release form to return to play.

Remember: Concussion affects people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.
To learn more, go to www.cdc.gov/concussion.

Parents/Legal Guardians and Athletes (under 18) Must Sign and Return the Application for Participation Form

Special Olympics Michigan
Central Michigan University, Mt. Pleasant, MI 48859
Phone: 800-644-6404 Fax: 989-774-3034
www.somi.org Email: somiforms@smi.org Facebook: Special Olympics Michigan Twitter & Instagram @SpOlympicsMI

Created by the Joseph P. Kennedy Jr. Foundation for the benefit of persons with intellectual disabilities