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

COUNTY_____ ****SOC. SEC #**_____----_____----_____ **DATE OF BIRTH** ____/____/____
(**REQUIRED IF 18 OR OLDER)

☐ FEMALE or ☐ MALE ☐ **NEW** ATHLETE or ☐ **CURRENT** ATHLETE

ATHLETE INFORMATION

NAME _____

ADDRESS _____

CITY/STATE/ZIP _____

HOME PHONE (____) _____--_____

CELL PHONE (____) _____--_____

E-MAIL _____

HEALTH/ACCIDENT INSURANCE CO _____

POLICY # _____

ETHNICITIES (OPTIONAL) CHECK ALL THAT APPLY:

☐ CAUCASIAN ☐ ASIAN AMERICAN ☐ AFRICAN AMERICAN

☐ MEXICAN ☐ CARIBBEAN ☐ HISPANIC ☐ OTHER

ATHLETE SCHOOL / AGENCY / EMPLOYER

NAME_____

ADDRESS_____

CITY/STATE/ZIP _____

PHONE (____) _____--_____

PARENT / GUARDIAN INFORMATION

NAME _____

ADDRESS _____

CITY/STATE/ZIP _____

HOME PHONE (____) _____--_____

CELL PHONE (____) _____--_____

E-MAIL _____

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

HAS ATHLETE EVER BEEN CHARGED / CONVICTED OF A CRIMINAL OFFENSE?	□ YES*	□ NO
HAS ATHLETE EVER BEEN CHARGED WITH ABUSE OR 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 NECESSARILY EXCLUDE APPLICANT FROM PARTICIPATION IN SPECIAL OLYMPICS MARYLAND ACTIVITIES.

CRIMINAL BACKGROUND CHECKS WILL BE PERFORMED FOR INDIVIDUALS 18 YEARS OF AGE AND OLDER

*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 AND ATTACH TO THIS FORM

MEDICATIONS (Attach separate form if necessary)

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

SIGN

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

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

PLEASE COMPLETE SIDES TWO & THREE OF THIS APPLICATION

APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS MARYLAND / SIDE 2 OF 3

THIS SECTION MUST BE COMPLETED BY A LICENSED PHYSICIAN

PHYSICAL EXAMINATION (THIS SECTION MUST BE COMPLETED FOR THE APPLICATION TO BE ACCEPTED)

ATHLETE NAME _____ IF PREGNANT, DUE DATE _____/_____/_____

BLOOD PRESSURE _____ HEIGHT _____ft _____inches WEIGHT _____lbs

PRIMARY INTELLECTUAL DISABILITY ETIOLOGY / CATEGORY:

- ☐ AUTISM
- ☐ DEAF – BLINDNESS
- ☐ DEVELOPMENTAL DELAY (PLEASE SPECIFY) _____
- ☐ INTELLECTUAL DISABILITY (PLEASE SPECIFY) _____
- ☐ SPECIFIC LEARNING DISABILITY (PLEASE SPECIFY) _____
- ☐ TRAUMATIC BRAIN INJURY
- ☐ MULTIPLE DISABILITIES, COGNITIVE (PLEASE SPECIFY) _____
- ☐ OTHER (PLEASE BE SPECIFIC) _____

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 RADIOGRAPHYS 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 ANTLANTO-DENS INTERVAL 5MM OR MORE?

NORMAL	ABNORMAL	NORMAL	ABNORMAL	NORMAL	ABNORMAL	NORMAL	ABNORMAL
☐	☐ VISION	☐	☐ CARDIOVASCULAR SYSTEM	☐	☐ RESPIRATORY SYSTEM	☐	☐ NECK
☐	☐ HEARING	☐	☐ GENITO-URINARY SYSTEM	☐	☐ CRANIAL NERVES	☐	☐ SKIN
☐	☐ ORAL CAVITY	☐	☐ GASTROINTESTNAL SYSTEM	☐	☐ COORDINATION	☐	☐ REFLEXES
☐	☐ EXTREMITIES						

COMMENTS / RESTRICTIONS: _____

Physician Signature

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 _____/_____/_____

OFFICIAL SPECIAL OLYMPICS RELEASE FORM

On behalf of myself, or my minor child, I represent and warrant that, to the best of my knowledge and belief, I, or my minor child, am / is physically and mentally able to participate in Special Olympics activities. On behalf of myself or my minor child I also represent that a licensed physician has reviewed the health information contained in this application and has certified based on an independent medical examination, that there is no medical evidence which would preclude me, or my minor child, from participating in Special Olympics. I understand that if I, or my minor child, have / has Down syndrome, I 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 I, or my minor child, have/has a full radiological examination which established the absence of Atlanto-axial instability. I am aware that I, or my minor child, must have this radiological examination before I, or my minor child, can participate in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, flag football and soccer.

Special Olympics has my permission, (both during and anytime after) to use my, or my minor child'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, during my, or my minor child's, participation in Special Olympics activities, I, or my minor child, 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, or my minor child's, health and well-being, including, if necessary, hospitalization.

Adult Participant & Witness Signatures

SIGNATURE OF ADULT ATHLETE (18 YEARS OF AGE OR OLDER)

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. Furthermore, I give my Special Olympics Maryland my permission to use my social security number to perform a criminal background check.

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_____

* * * * * * * * OR * * * * * * * *

Parent / Guardian Signature

SIGNATURE OF PARENT / GUARDIAN OF MINOR ATHLETE (FOR ATHLETES 17 YEARS OLD AND YOUNGER)

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, physical activity programs, and Healthy Athletes screenings.

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

Name (print) _____

HOUSING & CONCUSSION WAIVER / APPLICATION SIDE THREE OF THREE

NAME _____ COUNTY _____

DATE OF BIRTH_____/_____/_____

☐ FEMALE or ☐ MALE ☐ ATHLETE or ☐ VOLUNTEER ☐ NEW PARTICIPANT or ☐ CURRENT

SPECIAL OLYMPICS MARYLAND HOUSING POLICY

The health and safety of all Special Olympics Maryland participants is of paramount importance to Special Olympics Maryland. Participants should feel that every Special Olympics Maryland event is a safe and positive experience and should not be fearful of other participants, 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 www.somd.org

Adult Athlete & Witness Signatures

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 participant _____ Date _____/_____/_____

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

Name (print) _____ Relationship to participant: _____

* * * * * * * * OR * * * * * * * *

Parent / Guardian Signature

IF PARTICIPANT 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. Participants 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 participant 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 participant 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 participant even suspected of suffering a concussion should be removed from the game or practice immediately. No participant 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 participant 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 participant 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 participant is evaluated by a licensed heath 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 current and up-to-date information on concussions you can go to: http://www.cdc.gov/Concussion

IF PARTICIPANT IS AN ADULT:

Adult Athlete & Witness Signatures

Signature of ADULT participant _____ Date _____/_____/_____

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

Name (print) _____ Relationship to participant: _____

* * * * * * * * OR * * * * * * * *

IF PARTICIPANT IS A MINOR (17 Years of age or younger):

Parent / Guardian Signature

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

Name (print) _____