

**INSTRUCTIONS**

**Athlete Name:** \_\_\_\_\_

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

1. Each athlete must have the Official Special Olympics Release Form and the Application for Participation in Special Olympics Form on file with Special Olympics Virginia prior to participating. The Official Special Olympics Release Form must be signed by a *parent, legal guardian, or adult athlete*. The Release Form only needs to be completed one time and is good for as long as the athlete remains a participant in the program.
2. When completing this *NEW* Application for Participation in Special Olympics for the first time (SOVA began using this form on March 1, 2000), fill out all parts of this form; Section A, *Athlete Health Information* and Section B, *Medical Certification* completely.
3. Section A of this form must be updated and submitted once every three years in order for the athlete to maintain eligibility in the program. Section A can be completed by a parent, guardian, caseworker, teacher, etc. Section B must be completed every three years for athletes with *Yes* in Items 1-6 or the first time *New* is checked in Items 7-12. Please make sure the Down syndrome information, *Item 1, Section A*, is filled out completely. Athletes with Down syndrome need cervical spine x-rays in order to participate in certain sports. If an athlete has Down syndrome with Atlanto-axial Instability checked YES, the athlete will be restricted from sports requiring hyper-extension, radical flexion or direct pressure on the neck and upper spine. Athletes with Down syndrome who have not had x-rays or who leave the spaces under cervical spine x-rays or Atlanto-axial blank will also be restricted.
4. Section B, *Medical Certification*, must be completed by a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Licensed Nurse Practitioner (NP), or a Licensed Physician's Assistant (PA). Make sure that the examiner records the date on which the exam was given. Without a date, the form will be invalid. Please be sure the name, address, and telephone number of the person who provides the physical examination is clearly printed under the signature space in Section B (a stamped impression of this information is satisfactory).
5. Return the completed form to Special Olympics Virginia, P.O. Box 1906, Harrisonburg, VA 22801 or return the form to your local Special Olympics representative.

**Official Special Olympics Release Form**

I represent and warrant that to the best of my knowledge and belief I am/my child is physically and mentally able to participate in Special Olympics. I also represent that a licensed examiner has reviewed the health information set forth in my/my child's application and has certified, based on an independent medical examination, that there is no medical evidence which would preclude my/my child's participation. I understand that if I/my child has Down syndrome, I/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 I and two physicians have completed the official "Special Release for Athletes with Atlanto-axial Instability" form or I/my child 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, I/my child must have a radiological examination before I/he/she can participate in equestrian, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, squat lift and soccer.

Special Olympics has my permission (both during and anytime after) to use my/my child's likeness, name, voice, or words in either television, radio, film, newspapers, magazines and other media 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 my/my child's participation in Special Olympics activities at a time when I am not personally able/present to be consulted regarding my/my child's care, I authorize Special Olympics to take whatever measures are necessary to protect my/my child's health and well-being, including, if necessary, hospitalization. I also give permission for the athlete named in this Release Form to participate in optional health education and screening activities such as dental, vision and hearing screenings.

I, the undersigned, have read and fully understand the provisions of the above release, and if I am an adult athlete someone has explained these provisions to me. By signing this release form I agree to the above provisions. If I am the parent/guardian of the athlete named on this form I am agreeing to the above provisions on my own behalf and on behalf of the athlete named on this application. If I am a witness for an adult athlete I certify that I have reviewed this release with the athlete and am satisfied that the athlete understands this release and has agreed to its terms.

Signature of Athlete: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Witness for Adult Athlete: \_\_\_\_\_ Date: \_\_\_\_\_

**IMPORTANT:** If there is any significant change in the athlete's health, the athlete's condition should be reviewed by a licensed examiner before further participation. A physical examination performed by a licensed examiner is required for initial participation. A physical examination performed by a licensed examiner is required every 3 years for athletes with YES in items 1-6 on the Athlete Health Information. An exam is required the first time NP (New Problem) is checked in items 7-12 on the Athlete Health Information.

**Application: Section B ~ Medical Certification**

**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: equestrian, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, squat lift and soccer.

I have reviewed the athlete's medical history and examined the athlete named in the application and certify there is no medical evidence available to me which would preclude the athlete's participation in Special Olympics.

Restrictions \_\_\_\_\_

Examiner's Signature \_\_\_\_\_

Examiner's Name \_\_\_\_\_

Date \_\_\_\_\_  
PLEASE PRINT CLEARLY

Examiner's Address \_\_\_\_\_

Phone \_\_\_\_\_

**Athlete Information:**

**PLEASE PRINT CLEARLY**

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

Athlete Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_  
 E-mail Address: \_\_\_\_\_

Gender:  M  F  
 Date of Birth (month/day/year) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Home Phone: \_\_\_\_\_  
 Cell / Work Phone: \_\_\_\_\_

**Parent/Guardian Information:**

Parent/Guardian Name: \_\_\_\_\_  
 Address (if different than athlete):  
 \_\_\_\_\_  
 \_\_\_\_\_

Home Phone: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_  
 E-mail: \_\_\_\_\_

**Emergency Contact Information:** (other than parent/guardian): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell / Work Phone: \_\_\_\_\_

**Athlete Background Information – Answers are not automatic disqualifiers for participation in Special Olympics Virginia.**

**1) Was the athlete ever charged or convicted of a crime?**  
 Yes  No

**2) Does the athlete have any behavior issues?**  
 Yes  No

Explain YES answer and indicate date, location and nature of offense:

Explain YES answer:

- 1. Down Syndrome  Yes  No
- Have cervical spine (neck bone) x-rays ever been done?  Yes  No
- Atlanto-Axial Instability  Yes  No
- 2. Chest Pain or Fainting Spells  Yes  No
- 3. Seizures/ Epilepsy  Yes  No
- 4. Diabetes  Yes  No
- 5. Heart Disease/ Heart Defect/ High Blood Pressure  Yes  No
- 6. Parent/ Sibling (under 40) died of heart disease  Yes  No
- 7. Absence of vision/ blind in one eye  Yes  No  NP
- 8. Absence of one kidney or testicle  Yes  No  NP
- 9. Concussion or serious head injury  Yes  No  NP
- 10. Major surgery or serious illness  Yes  No  NP
- 11. Heat stroke/ exhaustion  Yes  No  NP
- 12. Other problem that would interfere with sports participation  Yes  No  NP

- 13. Impaired motor ability  Yes  No
- 14. Uses a wheelchair  Yes  No
- 15. Allergy to the following (list specific)  Yes  No
- Medicine \_\_\_\_\_  Yes  No
- Foods \_\_\_\_\_  Yes  No
- Insect Sting/Bite \_\_\_\_\_  Yes  No
- 16. Special diet \_\_\_\_\_  Yes  No
- 17. Exercise induced wheezing  Yes  No
- 18. Tendency to bleed easily  Yes  No
- 19. Emotional/ psychiatric/ behavioral problems  Yes  No
- 20. Serious bone or joint disorder  Yes  No
- 21. Sickle cell trait or disease  Yes  No
- 22. Hearing aid/ hearing loss  Yes  No
- 23. Contact lenses/ eyeglasses  Yes  No
- 24. Dentures/ false teeth  Yes  No
- 25. Immunizations (shots) are up-to-date  Yes  No
- 26. Date of last tetanus shot \_\_\_\_/\_\_\_\_/\_\_\_\_

**A physical examination performed by a licensed examiner is required every 3 years for athletes with YES in items 1-6. An exam is required the first time NP (New Problem) is checked in items 7-12.**

Comments: \_\_\_\_\_

<b>Medication Update</b> * Attach additional sheet if needed.	Medication Name	Amount (eg. 250 mg)	Date Prescribed	Amount Taken (Dosage and instructions, ex. 250 mg 2 X per day with food)

Signature of Person Completing Section A: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship to athlete: \_\_\_\_\_ Date: \_\_\_\_\_