**Knox County Special Olympics - Athlete Packet**

# Special Olympics Ohio (SOOH) Medical and Release Form Instructions

## Please Read Before Completing SOOH Forms

Special Olympics Incorporated has issued medical and release forms that State Chapters must use. Below are instructions for each of the forms **REQUIRED** by Special Olympics Ohio for Athletes to participate. If you have any questions regarding the forms, please reach out to Talisha Beha.

**Completed Packets can be submitted by**

**Mail or Drop Off** – 11700 Upper Gilchrist Rd Suite A, Mt. Vernon OH 43050 (attn: Talisha Beha)
**Original, Completed Documents are Required.**

**Athlete Registration Form**

This page needs to be completed. Each section needs to be completed in full.

**Athlete Medical Form – Health History (2 pages)**

Sections need to be filled out before the athlete's physical examination.
Please fill out as much information as possible.
***Signature required at the bottom of 2nd page.**

**Athlete Medical Form – Physical Exam**

**Must be completed by a Licensed Medical Professional**
Make sure the athlete's name is filled out at the top of this form. All information the doctor feels comfortable completing will be accepted.
**The doctor must fill out the ATHLETE CLEARANCE TO PARTICIPATE area.**
***Doctor's signature, license number and contact info required.**
**No attached medical documents or signatures will be accepted.**

**Athlete Release Form**

This form needs to be filled out and signed by the athlete or their guardian if they have one. There must be a signature and date on this form.
***Signature of athlete and/or Guardian required at the bottom of the page.**

## If you have any questions, please contact:

**Talisha Beha**
Special Olympics Coordinator
Integration and Family Engagement Coordinator
330-390-5175
tbeha@knoxdd.com

# ATHLETE REGISTRATION FORM

Special Olympics

**State Special Olympics Program:** Ohio **Local Area/Delegation:** _____

**Are you a new athlete to Special Olympics or Re-Registering?** ☐ New Athlete ☐ Re-Registering

| **ATHLETE INFORMATION** | | |
|---|---|---|
| **First Name:** | **Middle Name:** | |
| **Last Name:** | **Preferred Name:** | |
| **Date of Birth (mm/dd/yyyy):** | ☐ Female ☐ Male ☐ Other Gender Identity | |
| **Race/Ethnicity:** ☐ Prefer not to answer<br>☐ American Indian/Alaskan Native ☐ Asian American ☐ More than one race<br>☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander<br>☐ White or Caucasian ☐ Hispanic or Latinx | | |
| **Language(s) Spoken in Athlete's Home (Optional):** Check all that apply<br>☐ 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)** | | |
| **Name**: | | |
| **Relationship:** | | |
| ☐ **Same Contact Info as Athlete** | | |
| **Street Address:** | | |
| **City:** | **State:** | **Zip Code:** |
| **Phone:** | **E-mail:** | |
| **EMERGENCY CONTACT INFORMATION** | | |
| ☐ **Same as Parent/Guardian** | | |
| **Name:** | | |
| **Phone:** | **Relationship:** | |
| **PHYSICIAN & INSURANCE INFORMATION** | | |
| **Physician Name:** | | |
| **Physician Phone:** | | |
| **Insurance Company:** | **Insurance Policy Number:** | |
| **Insurance Group Number:** | | |

# Athlete Medical Form – **HEALTH HISTORY**

**(To be completed by the athlete or parent/guardian/caregiver and brought to exam)**

**Athlete First & Last Name:**_____ **Preferred Name:**_____

**Athlete Date of Birth** (mm/dd/yyyy):_____ ☐ Female ☐ Male ☐ Other Gender Identity

**STATE PROGRAM:** Ohio **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:_____

## ALLERGIES & DIETARY RESTRICTIONS

☐ No Known Allergies

☐ Latex

☐ Medications:_____

☐ Insect Bites or Stings:_____

☐ Food:_____

## 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

**Aggressive behavior during the past year** ☐ No ☐ Yes

**Depression** *(diagnosed)* ☐ 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 Medical Form – **HEALTH HISTORY**

**(To be completed by the athlete or parent/guardian/caregiver and brought to Exam)**

**Athlete's First and Last Name:**_____

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

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Loss of Consciousness | ☐ No | ☐ Yes | High Blood Pressure | ☐ No | ☐ Yes | Stroke/TIA | ☐ No | ☐ Yes |
| Dizziness during or after exercise | ☐ No | ☐ Yes | High Cholesterol | ☐ No | ☐ Yes | Concussions | ☐ No | ☐ Yes |
| Headache during or after exercise | ☐ No | ☐ Yes | Vision Impairment | ☐ No | ☐ Yes | Asthma | ☐ No | ☐ Yes |
| Chest pain during or after exercise | ☐ No | ☐ Yes | Hearing Impairment | ☐ No | ☐ Yes | Diabetes | ☐ No | ☐ Yes |
| Shortness of breath during or after exercise | ☐ No | ☐ Yes | Enlarged Spleen | ☐ No | ☐ Yes | Hepatitis | ☐ No | ☐ Yes |
| Irregular, racing or skipped heart beats | ☐ No | ☐ Yes | Single Kidney | ☐ No | ☐ Yes | Urinary Discomfort | ☐ No | ☐ Yes |
| Congenital Heart Defect | ☐ No | ☐ Yes | Osteoporosis | ☐ No | ☐ Yes | Spina Bifida | ☐ No | ☐ Yes |
| Heart Attack | ☐ No | ☐ Yes | Osteopenia | ☐ No | ☐ Yes | Arthritis | ☐ No | ☐ Yes |
| Cardiomyopathy | ☐ No | ☐ Yes | Sickle Cell Disease | ☐ No | ☐ Yes | Heat Illness | ☐ No | ☐ Yes |
| Heart Valve Disease | ☐ No | ☐ Yes | Sickle Cell Trait | ☐ No | ☐ Yes | Broken Bones | ☐ No | ☐ Yes |
| Heart Murmur | ☐ No | ☐ Yes | Easy Bleeding | ☐ No | ☐ Yes | Dislocated Joints | ☐ No | ☐ Yes |
| Endocarditis | ☐ No | ☐ Yes | **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:**

## Neurological Symptoms for Spinal Cord Compression and Atlanto-axial Instability

| | | | | | |
|---|---|---|---|---|---|
| **Difficulty controlling bowels or bladder** | ☐ No | ☐ Yes | *If yes, is this new or worse in the past 3 years?* | ☐ No | ☐ Yes |
| **Numbness or tingling in legs, arms, hands or feet** | ☐ No | ☐ Yes | *If yes, is this new or worse in the past 3 years?* | ☐ No | ☐ Yes |
| **Weakness in legs, arms, hands or feet** | ☐ No | ☐ Yes | *If yes, is this new or worse in the past 3 years?* | ☐ No | ☐ Yes |
| **Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet** | ☐ No | ☐ Yes | *If yes, is this new or worse in the past 3 years?* | ☐ No | ☐ Yes |
| **Head Tilt** | ☐ No | ☐ Yes | *If yes, is this new or worse in the past 3 years?* | ☐ No | ☐ Yes |
| **Spasticity** | ☐ No | ☐ Yes | *If yes, is this new or worse in the past 3 years?* | ☐ No | ☐ Yes |
| **Paralysis** | ☐ No | ☐ Yes | *If yes, is this new or worse in the past 3 years?* | ☐ No | ☐ Yes |

## PLEASE LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW

*(includes inhalers, birth control or hormone therapy)*

| *Medication, Vitamin or Supplement Name* | *Dosage* | *Times per Day* | *Medication, Vitamin or Supplement Name* | *Dosage* | *Times per Day* | *Medication, Vitamin or Supplement Name* | *Dosage* | *Times per Day* |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

**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:**_____ **Date of Birth**_____

## MEDICAL PHYSICAL INFORMATION

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

| Height | Weight | BMI *(optional)* | Temperature | Pulse | $O_2$Sat | Blood Pressure (in mmHg) | | Vision |
|---|---|---|---|---|---|---|---|---|
| cm | kg | BMI | C | | | BP Right: | BP Left: | Right Vision 20/40 or better ☐ No ☐ Yes ☐ N/A |
| in | lbs | Body Fat % | F | | | | | Left Vision 20/40 or better ☐ No ☐ Yes ☐ N/A |

| | | | | |
|---|---|---|---|---|
| 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 | | |

| | | | | | |
|---|---|---|---|---|---|
| Bowel Sounds | ☐ Yes | ☐ No | | | |
| Hepatomegaly | ☐ No | ☐ Yes | | | |
| Splenomegaly | ☐ No | ☐ Yes | | | |
| Abdominal Tenderness | ☐ No | ☐ RUQ | ☐ RLQ | ☐ LUQ | ☐ LLQ |
| Kidney Tenderness | ☐ No | ☐ Right | ☐ Left | | |
| Right upper extremity reflex | ☐ Normal | ☐ Diminished | ☐ Hyperreflexia | | |
| Left upper extremity reflex | ☐ Normal | ☐ Diminished | ☐ Hyperreflexia | | |
| Right lower extremity reflex | ☐ Normal | ☐ Diminished | ☐ Hyperreflexia | | |
| Left lower extremity reflex | ☐ Normal | ☐ Diminished | ☐ Hyperreflexia | | |
| Abnormal Gait | ☐ No | ☐ Yes, describe below | | | |
| Spasticity | ☐ No | ☐ Yes, describe below | | | |
| Tremor | ☐ No | ☐ Yes, describe below | | | |
| Neck & Back Mobility | ☐ Full | ☐ Not full, describe below | | | |
| Upper Extremity Mobility | ☐ Full | ☐ Not full, describe below | | | |
| Lower Extremity Mobility | ☐ Full | ☐ Not full, describe below | | | |
| Upper Extremity Strength | ☐ Full | ☐ Not full, describe below | | | |
| Lower Extremity Strength | ☐ Full | ☐ Not full, describe below | | | |
| Loss of Sensitivity | ☐ No | ☐ Yes, describe below | | | |

## 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.**

**OR**

☐ **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 ☐ Acute Infection ☐ $O_2$ Saturation Less than 90% on Room Air

☐ Concerning Neurological Exam ☐ Stage II Hypertension or Greater ☐ 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 neurologist ☐ Follow up with a primary care physician

☐ Follow up with a vision specialist ☐ Follow up with a hearing specialist ☐ Follow up with a dentist or dental hygienist

☐ Follow up with a podiatrist ☐ Follow up with a physical therapist ☐ Follow up with a nutritionist

☐ Other/Exam Notes:

| | |
|---|---|
| | Name: |
| | E-mail: |
| **Signature of Licensed Medical Examiner** Exam Date | Phone: License #: |

# ATHLETE RELEASE FORM

Special Olympics

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.
     - using my contact information for communicating with me about Special Olympics.
     - 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.

| | |
|---|---|
| **Athlete Name:** | |
| **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.** | |
| **Athlete Signature:** | **Date:** |
| **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.** | |
| **Parent/Guardian Signature:** | **Date:** |
| **Printed Name:** | **Relationship:** |