Special Olympics Arizona
3816 North 7th Street
Phoenix, AZ 85014-5004
602-230.1200/800.289.4946
Fax: 602.230.1110

MEDICAL/PARENTAL RELEASE FORM

PROGRAM NAME: _____

AREA #: _____ **PROGRAM #:** _____

DEMOGRAPHICS

Athlete's First Name _____ MI _____ Last Name _____
Athlete's Social Security # (Optional): _____-_____-_____ Gender: Male ❑ Female ❑
Athlete's Date of Birth: (M/D/Y) ____/____/_____ Athlete's Email Address: _____
Athlete's Address: _____
City: _____ State: _____ Zip: _____
Athlete's Home Phone # : (_____)_____
Parent/Guardian's Name: _____
Parent/Guardian's Address (If different than above): _____
City: _____ State: _____ Zip: _____
Parent Primary Phone #: (_____)_____ Parent Email Address: _____
Emergency Contact Name (if other than parent/guardian): _____
Emergency Contact Phone #: (_____)_____
Health/Accident Insurance Co: _____ Policy #: _____

HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER

Yes	No		Yes	No		Yes	No	
❑	❑	Heart Disease/Heart Defect/High Blood Pressure	❑	❑	Requires Extra Supervision	❑	❑	Tobacco Use
❑	❑	Diabetes	❑	❑	Deaf	❑	❑	Heat Stroke/Exhaustion
❑	❑	Seizures/Epilepsy/Fainting Spells	❑	❑	Hearing Loss/Hearing Aid	❑	❑	Shunts
❑	❑	Asthma	❑	❑	Hepatitis	❑	❑	Chest Pain
❑	❑	Blind	❑	❑	Concussion/Head injury	❑	❑	Easy Bleeding
❑	❑	Visually Impaired	❑	❑	Major Surgery/Serious Illness	❑	❑	Bone or Joint Problem
❑	❑	Contact Lenses/Glasses	❑	❑	Immunizations up to Date	❑	❑	Sickle Cell Trait or Disease
❑	❑	Allergies: Insect Stings/Bites: _____	❑	❑	Special Diet _____			
❑	❑	Allergies: Food: _____	❑	❑	Emotional/Psychiatric/Behavioral			
❑	❑	Allergies: Medicines: _____	❑	❑	Other _____			

Date of most recent Tetanus Immunization: _____/_____/_____

MEDICATIONS: Please print medication name, amount, date prescribed and number of times per day given. All changes in medication should be submitted to Special Olympics Arizona. For more space, attach additional paper.

Medication Name	Dosage	Date Prescribed	Times Per Day

Signature of parent/caregiver/adult athlete: _____ **Date:**____/____/____

PHYSICAL EXAMINATION: TO BE COMPLETED BY MEDICAL EXAMINER

Blood Pressure: _____/_____ Weight: _____ Height: _____

Normal	Abnormal		Normal	Abnormal		Normal	Abnormal		Normal	Abnormal	
❑	❑	Vision	❑	❑	Cardiovascular System	❑	❑	Cranial Nerves	❑	❑	Skin
❑	❑	Hearing	❑	❑	Respiratory System	❑	❑	Genitourinary System	❑	❑	Neck
❑	❑	Oral Cavity	❑	❑	Gastrointestinal System	❑	❑	Coordination	❑	❑	Reflexes
									❑	❑	Extremities

Other: _____
Primary MR: _____

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 hypertension, 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, artistic gymnastics, diving, pentathlon, butterfly stroke and diving starts in swimming, high jump, alpine skiing, snowboarding, squat lift, and football team competition (soccer). **PLEASE CIRCLE THE FOLLOWING:** Does the athlete have Down Syndrome? **Yes No**
If yes, has an x-ray for Atlanto-axial instability been done? **Yes No** (If no, the athlete will be restricted from above sports/events.)
X-Ray Date: _____ If yes, was it positive for Atlanto-axial instability? (the Atlanto-dens interval is 5mm or more) **Yes No** If yes, the athlete will be restricted from above sports/events unless the "Special Release for Athletes with Atlanto-Axial Instability" form is completed.
I have reviewed the above health information and have preformed 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: _____
City: _____ State: _____ Zip: _____ Phone: (_____)_____
This form is valid for 3 years unless otherwise stated. Optional expiration date: _____/_____/_____ **REV: 5/2003**

OFFICIAL SPECIAL OLYMPICS ARIZONA RELEASE FORM

RELEASE TO BE COMPLETED BY ADULT ATHLETE

I, _____(athlete's name) am at least 18 years old and have submitted the attached application for participation in Special Olympics.

I represent and warrant that, to the best of my knowledge and belief, I am physically and mentally able to participate in Special Olympics activities. I also represent that a licensed physician has reviewed the health information contained in my application and has certified, based on an independent medical examination, that there is no medical evidence which would preclude me from participating in Special Olympics. I understand that if I have Down Syndrome, I cannot participate in sports or events which, by their nature, result in hyper-extension, radical flexion or direct pressure on my neck or upper spine unless I and two physicians have completed the official "Special Release for Athletes with Atlanto-Axial Instability," available form the Special Olympics Chapter program in my state, or I have 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 which establishes the presence of Atlanto-axial Instability, I must have the radiological examination before I can participate in 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). Special Olympics has my permission, (both during and anytime after), to use my likeness, name, voice or words in wither 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 these purposes and activities.

If, during my participation in Special Olympics activities, I should need emergency medical treatment, and I am not able to give my consent or make my own arrangements for that treatment because of my injuries, I authorize Special Olympics to take whatever measures are necessary to protect my health and well-being, including, if necessary, hospitalization.

I, the athlete named above, have read this paper and fully understand the provisions for the release that I am signing. I understand that by signing this paper, I am saying that I agree to the provisions of this release.

_____ _____

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 its terms.

Name (Print) _____

Relationship to athlete _____

(e.g. family member, teacher, coach, etc.)

THIS FORM IS VALID FOR THREE YEARS

RELEASE TO BE COMPLETED BY PARENT OR GUARDIAN OF MINOR ATHLETE

I am the parent/guardian of _____ (athlete's name), the athlete, on whose behalf I have submitted the attached application for participation in Special Olympics. I hereby represent that the athlete has my permission to participate in Special Olympics activities.

I further represent and warrant that to be best of my knowledge and belief, the athlete is physically and mentally able to participate in Special Olympics. With my approval, a licensed physician has reviewed the health information set forth in the athlete's application, and has certified based on an independent medical examination that there is no medical evidence, which would preclude the athlete's participation. I understand that if the athlete has Down Syndrome, 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." Available form the Special Olympics Chapter program in my state, or the athlete has had a full radiological examination, which establishes the absence o Atlanto-axial Instability. I am aware that if I choose not to compete the "Special Release for Athletes with Atlanto-Axial Instability" form which establishes the absence of Atlanto-axial Instability, the athlete must have the radiological examination before he/she can participate in 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).

In permitting the athlete to participate, I am specifically granting my permission, (both during and anytime after), to Special Olympics to use the athlete's likeness, name, voice and words in 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 these purposes and activities.

If a medical emergency should arise during the athlete's participation in any Special Olympics activities, at a time when I am not personally present so as to be consulted regarding the athlete's care, I hereby authorize Special Olympics, on my behalf, to take whatever measures are necessary to ensure that the athlete is provided with any emergency medical treatment, including hospitalization, which Special Olympics deems advisable in order to protect the athlete's health and well-being.

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 above.

I hereby give my permission for the athlete named above to participate in Special Olympics games, recreation programs, and physical activity programs.

_____ _____

Signature of Parent/Guardian **Date**

THIS FORM IS VALID FOR THREE YEARS

Created by the Joseph P. Kennedy Foundation for the Benefit of Citizens with Mental Retardation.

RETURN COMPLETED ORIGINAL FORM TO: Special Olympics Arizona, 3816 N. 7th Street, Phoenix, AZ 85014-5004. RETAIN COPIES FOR LOCAL, AREA and PERSONAL RECORDS.

REV: 7/2002