



## Become an Athlete

Through the power of sports, our athletes find joy, confidence and fulfillment — on the playing field and in life. Whether you are new to Special Olympics Pennsylvania or have been involved for years, we are excited you are part of the movement!

To register or re-register as a Special Olympics Pennsylvania athlete from the Greater Lehigh Valley Pocono Region, please complete:

The Registration Forms include:

- **REGISTRATION FORM (page 2):** Asks for general demographic and contact information.
- **RELEASE FORM (page 3):** Reviews important details about Special Olympics participation.
- **OPTIONAL LIKENESS RELEASE FOR SPONSORS (page 4):** Allows Special Olympics sponsors to use photos, videos and stories.
- **EMERGENCY MEDICAL CARE REFUSAL FORM (page 6 OR 7):** Required ONLY if on the Athlete Release Form athlete selected "*I have a religious or other objection to receiving medical treatment*" and/or "*I do not consent to a blood transition.*"
- **SELF-IDENTIFICATION STATEMENTS AND POLICY ACKNOWLEDGMENT (pages 8-16):** Reviews Special Olympics Pennsylvania policies.
- **HEALTH HISTORY (pages 17-18):** Asks for medical history.
- **SPORTS PHYSICAL EXAM FORM (page 19):** Indicates if the athlete has been cleared by a physician to participate in Special Olympics Pennsylvania sports.
  - The complete file (Health History and blank Sports Physical Exam Form) must be taken to your physician to have the exam done. The Sports Physical Exam Form needs to be completed and signed by a physician or authorized medical personnel (CRNPs, FNPs, and PAs).
- **MEDICAL REFERRAL FORM (page 20):** Required ONLY if an athlete requires further examination due to a concerning health issue before clearance can be determined.



The forms should be filled out by the person (or people) who can give the most complete and accurate account of the athlete's medical history. That might include the athlete themselves, the parent or guardian, or a caregiver. If the athlete cannot sign legal documents, then the person completing the form should be able to legally sign on behalf of the athlete.



## 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

<b>ATHLETE INFORMATION</b>		
<b>First Name:</b>	<b>Middle Name:</b>	
<b>Last Name:</b>	<b>Preferred Name:</b>	
<b>Date of Birth (mm/dd/yyyy):</b>	<input type="checkbox"/> Female <input type="checkbox"/> Male	
<b>Race/Ethnicity (Optional):</b>		
<input type="checkbox"/> American Indian/Alaskan	<input type="checkbox"/> Asian	<input type="checkbox"/> Two or More Races
<input type="checkbox"/> NativeBlack or African	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	
<input type="checkbox"/> American White	<input type="checkbox"/> Hispanic or Latino (specific origin group: _____)	
<b>Language(s) Spoken in Athlete's Home (Optional):</b> Check all that apply		
<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (please list): _____		
<b>Street Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>Phone:</b>	<b>E-mail:</b>	
<b>Sports/Activities:</b>		
<b>Athlete Employer, if any (Optional):</b>		
<b>Does the athlete have the capacity to consent to medical treatment on his or her own behalf?</b> Yes      No		
<b>PARENT / GUARDIAN INFORMATION (required if minor or otherwise has a legal guardian)</b>		
<b>Name:</b>		
<b>Relationship:</b>		
<b>Same Contact Info as Athlete</b>		
<b>Street Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>Phone:</b>	<b>E-mail:</b>	
<b>EMERGENCY CONTACT INFORMATION</b>		
<b>Same as Parent/Guardian</b>		
<b>Name:</b>		
<b>Phone:</b>	<b>Relationship:</b>	
<b>PHYSICIAN &amp; INSURANCE INFORMATION</b>		
<b>Physician Name:</b>		
<b>Physician Phone:</b>		
<b>Insurance Company:</b>	<b>Insurance Policy Number:</b>	
<b>Insurance Group Number:</b>		



## Athlete Release Form

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

<b>Athlete Name:</b>	
<b>ATHLETE SIGNATURE</b> (required for adult athlete with capacity to sign legal documents)	
<b>I have read and understand this form. If I have questions, I will ask. By signing, I agree to this form.</b>	
<b>Athlete Signature:</b>	<b>Date:</b>
<b>PARENT/GUARDIAN SIGNATURE</b> (required for athlete who is a minor or lacks capacity to sign legal documents)	
<b>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.</b>	
<b>Parent/Guardian Signature:</b>	<b>Date:</b>
<b>Printed Name:</b>	<b>Relationship:</b>



## Athlete Likeness Release For Sponsors (Optional)

Special Olympics relies on sponsors and partners to help support our mission. We often use photos, videos and stories of our athletes to show the impact of support by companies that sponsor Special Olympics. If you wish to allow your likeness to be used in this way, please read and sign below.

I agree to the following:

- I give permission to Special Olympics, Inc., Special Olympics games organizing committees, and Special Olympics accredited Programs (collectively "Special Olympics") and their sponsors and partners to use my likeness, photo, video, name, voice, words, and biographical information ("my likeness") to acknowledge the sponsors' and partners' support for Special Olympics.
- Special Olympics and its sponsors and partners will not use my Likeness to endorse commercial products or services.
- I understand I will not be compensated for the use of my Likeness.

<b>Athlete Name:</b>	
<b>ATHLETE SIGNATURE</b> (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.	
<b>Athlete Signature:</b>	<b>Date:</b>
<b>PARENT/GUARDIAN SIGNATURE</b> (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.	
<b>Parent/Guardian Signature:</b>	<b>Date:</b>
<b>Printed Name:</b>	<b>Relationship:</b>



## **Concussion Awareness and Safety Recognition Policy**

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### **Objective**

It is Special Olympics' intent to take steps to help ensure the health and safety of all Special Olympics participants. All Special Olympics participants should remember that safety comes first and should take reasonable steps to help minimize the risks for concussion or other serious brain injuries.

### **Defining a Concussion**

A concussion is defined by the Centers for Disease Control as a type of traumatic brain injury caused by a bump, blow, or jolt to the head as well as serial, cumulative hits to the head. Concussions can also occur from a blow to the body that causes the head and brain to move quickly back and forth—causing the brain to bounce around or twist within the skull. Although concussions are usually not life-threatening, their effects can be serious and therefore proper attention must be paid to individuals suspected of sustaining a concussion.

### **Suspected or Confirmed Concussion**

A participant who is suspected of sustaining a concussion in a practice, game or competition shall be removed from practice, play or competition at that time. If a qualified medical professional is available on-site to render an evaluation, that person shall have final authority as to the removal or return to play of the participant. If applicable, the participant's parent or guardian should be made aware that the participant is suspected of sustaining a concussion.

### **Return to Play**

A participant who has been removed from practice, play or competition due to a suspected concussion may not participate in Special Olympics sports activities until either of the following occurs (1) at least seven (7) consecutive days have passed since the participant was removed from play and a currently licensed, qualified medical professional provides written clearance for the participant to return to practice, play and competition or (2) a currently licensed, qualified medical professional determines that the participant did not suffer a concussion and provides written clearance for the participant to return to practice play immediately. Written clearance in either of the scenarios above shall become a permanent record.

The Centers for Disease Control website [www.cdc.gov/concussion](http://www.cdc.gov/concussion) provides additional resources relative to concussions that may be of interest to participants and their families.



## Emergency Medical Care Refusal Form – Athlete Completion

*(To be completed by adult athlete with capacity to sign legal documents)*

**Instructions:** Only complete this form if you do not consent to emergency medical care on religious or other grounds and have marked a box under the Emergency Care provision on the Athlete Release Form.

**I am a Special Olympics athlete with capacity to sign documents on my own behalf and agree to the following:**

1. **No Consent to Emergency Medical Care.** I understand that Special Olympics’ standard registration form requires athletes or their parents or guardians to consent to emergency medical care for the athlete if needed in an emergency. Based on religious beliefs or other reasons I am not consenting to emergency medical care.

**YOU MUST MARK THE BOX AND WRITE YOUR INITIALS NEXT TO ONE STATEMENT TO CONFIRM YOUR INTENT:**

- I DO NOT CONSENT TO ANY KIND OF MEDICAL TREATMENT, EVEN IN A LIFE-THREATENING EMERGENCY. INITIALS: \_\_\_\_\_**
  - I DO NOT CONSENT TO BLOOD TRANSFUSIONS, EVEN IN A LIFE-THREATENING EMERGENCY. I CONSENT TO ALL OTHER KINDS OF EMERGENCY MEDICAL CARE. INITIALS: \_\_\_\_\_**
2. **Printed Instructions.** I agree to carry printed instructions that describe my religious or other objections to medical treatment and how I wish the person accompanying me to respond if I get sick or hurt and cannot speak for myself. I agree to carry these printed instructions with me at all times during my participation in any Special Olympics activity, including during meal times, in overnight accommodations, at training sessions and competitions, and during travel to and from Special Olympics activities.
  3. **Friend or Family Accompaniment.** I understand that I must be accompanied by an adult friend or family member in order for that person can take personal responsibility for me during a medical emergency where I am unable to speak for myself.
  4. **Emergency Medical Care if Athlete Is Not Accompanied.** I understand that, if I am not carrying the printed instructions **or** the accompanying adult is not present and actively taking personal responsibility for me during a medical emergency where I am unable to speak for myself, Special Olympics may seek emergency medical care for me as recommended by medical professionals responding to the emergency.
  5. **Liability Release.** I release Special Olympics, its employees, and its volunteers from all claims that may arise out of taking or failing to take measures to provide me with emergency medical care. I am agreeing to this release because I have refused, knowingly and voluntarily, to give Special Olympics permission to take emergency measures, and I am expressly withholding consent to emergency medical care on religious or other grounds. For this form, “Special Olympics” means all Special Olympics organizations.

<b>Athlete Name:</b>	<b>E-mail:</b>
<b>ATHLETE SIGNATURE</b>	
<b>I have read and understand this form. If I have questions, I will ask. By signing, I agree to this form.</b>	
<b>Athlete Signature:</b>	<b>Date:</b>
<b>SIGNATURE OF ACCOMPANYING ADULT</b>	
<b>By signing, I agree to accompany the athlete during Special Olympics activities and take personal responsibility for the athlete during an emergency. I understand the extent to which the athlete does not consent to emergency medical care and agree to act in accordance with the athlete’s wishes as I understand them.</b>	
<b>Signature of Accompanying Adult:</b>	<b>Date:</b>
<b>Printed Name:</b>	<b>Relationship:</b>



## Emergency Medical Care Refusal Form – Parent or Guardian Completion

*(To be completed by parent or guardian of athlete who is a minor or lacks capacity to sign legal documents)*

**Instructions:** Only complete this form if you do not consent to emergency medical care on religious or other grounds and have marked a box under the Emergency Care provision on the Athlete Release Form.

**I am the parent/guardian of the athlete named below and agree to the following:**

- No Consent to Emergency Medical Care.** I understand that Special Olympics' standard registration form requires athletes or their parents or guardians to consent to emergency medical care for the athlete if needed in an emergency. Based on religious beliefs or other reasons I am not consenting to emergency medical care as follows.

**YOU MUST MARK THE BOX AND WRITE YOUR INITIALS NEXT TO ONE STATEMENT TO CONFIRM YOUR INTENT:**

- I DO NOT CONSENT TO ANY KIND OF MEDICAL TREATMENT, EVEN IN A LIFE-THREATENING EMERGENCY. INITIALS: \_\_\_\_\_**
  - I DO NOT CONSENT TO BLOOD TRANSFUSIONS, EVEN IN A LIFE-THREATENING EMERGENCY. I CONSENT TO ALL OTHER KINDS OF EMERGENCY MEDICAL CARE. INITIALS: \_\_\_\_\_**
- Accompaniment of Athlete.** I understand that I must be present in order to take personal responsibility for the athlete if any medical treatment is to be refused on the athlete's behalf in a medical emergency arises. This includes during meal times, in overnight accommodations, at training sessions and competitions, and during travel to and from Special Olympics activities.
  - Emergency Medical Care If Athlete Is Not Accompanied.** I understand that, if I am not present and actively taking personal responsibility for the athlete during a medical emergency, Special Olympics may seek emergency medical care for the athlete as recommended by medical professionals responding to the emergency.
  - Liability Release.** On behalf of myself and the athlete, I release Special Olympics, its employees, and its volunteers from all claims that may arise out of taking or failing to take measures to provide the athlete with emergency medical care. I am agreeing to this release because I have refused, knowingly and voluntarily, to give Special Olympics permission to take emergency measures, and I am expressly withholding consent to emergency medical care on religious or other grounds. For this form, "Special Olympics" means all Special Olympics organizations.

<b>Athlete Name:</b>	<b>E-mail:</b>
<b>PARENT/GUARDIAN SIGNATURE</b>	
<p><b>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. This release shall be binding upon me, the athlete and our respective heirs and legal representatives.</b></p>	
<b>Parent/Guardian Signature:</b>	<b>Date:</b>
<b>Printed Name:</b>	<b>Relationship:</b>



## Self-Identification Statements and Policy Acknowledgment

**Athlete Eligibility:** To be eligible to participate in Special Olympics as an athlete, individuals must have an intellectual disability.

### What Is an Intellectual Disability?

Intellectual disability (or ID) is a term used when a person has certain limitations in cognitive functioning and skills, including communication, social and self-care skills. These limitations can cause a child to develop and learn more slowly or differently than a typically developing child. Intellectual disability can happen any time before a child turns 18 years old, even before birth. Intellectual disability is the most common developmental disability.

**Unified Partner Eligibility:** To be eligible to participate in Special Olympics as a Unified Partner, individuals must not have an intellectual disability.

**I have read, or have had read to me, the Special Olympics eligibility requirements for participation and confirm my roles as a (circle one):**

Special Olympics Athlete

Special Olympics Unified Partner

**Please review the following Special Olympics Pennsylvania policies. By checking the box you are attesting that you have read, or have had read to me, understand and agree to uphold.**

Code of Conduct

SOPA Housing Policy

**What is your highest level of education? (circle one)**

Some Education High

School Diploma

Associate's Degree/Some College

Bachelor's Degree

Master's Degree PhD

**What is your living setting? (circle one):**

Independent Living

Living with Parents or Other Family Members Group

Homes / Supportive Housing

Assisted Living Facilities / Skilled Nursing Facilities

**How did you hear about Special Olympics Pennsylvania? (circle one):**

The Arc

Achieva

Access Services

SPIN

Easter Seals

Other





## Special Olympics Pennsylvania Code of Conduct

*In an effort to become a more inclusive organization, Special Olympics Pennsylvania has created a Code of Conduct to help everyone of all ability levels understand how to appropriately conduct themselves and make SOPA a safe and fun organization for everyone involved.*

### GENERAL GUIDELINES

#### Respect & Sportsmanship:

- I will respect participants, coaches, officials, volunteers, spectators, training/competition facilities, SOPA Staff, and myself.
- I will respect the decision of officials and SOPA staff and will communicate any difference of opinion I may have in accordance to SOPA guidelines.
- I will respect all individuals regardless of their ability or limitations.
- I will demonstrate good sportsmanship at all times regardless win or lose.

#### Behavior:

- I will wear appropriate attire with pride to the delegation that is required at all times.
- I will keep my appearance and hygiene appropriate at all times.
- I will not use profanity or insulting language and/or gestures while representing Special Olympics PA.
- I will not smoke, use tobacco products, consume alcohol or take any drugs or drugs not prescribed to me while representing Special Olympics PA.
- I will not take pictures and/or videos of participants, coaches, officials, volunteers, spectators and SOPA Staff that may make them or someone else uncomfortable or are inappropriate.
- I will not engage in inappropriate contact, relationships, or any other physical/verbal/sexual advances or any conduct that may make someone else feel uncomfortable.
- I understand SOPA's No Dating Policy between athletes and volunteers/staff and I will contact SOPA's Senior VP of Programming if further explanation is required.
- I will represent Special Olympics PA with appropriate behavior in competitive and non competitive situations which include, but are not limited to: restrooms, locker rooms, housing and dining facilities.

#### Responsibility for Actions:

- I know that personal belongings (cell phone, hand held audio/video devices, wallet, keys, etc.) I bring to training, competition, and traveling are my responsibility and my local program and/or SOPA are not responsible.
- I will express any concerns I may have to the appropriate person in a positive manner.
- I will obey all local, state and Federal laws.
- I will follow all rules implemented by SOPA and/ or the host of any other event I am representing Special Olympics PA.

## **ATHLETE/UNIFIED PARTNER GUIDELINES**

### **Responsibility for Actions:**

- I will not use my cell phone and any other electronic devices while training and competing unless in an emergency.
- If I am caught using a personal device at an inappropriate time and/or in an inappropriate manner (i.e. making a phone call/texting during training and competition), I understand the device I used may be taken away by my coach(es) or local management team member for a period of time.
- I will follow all training, competition and travel instructions by my coach(es).
- I will stay with my delegation at all times.
- I will use locker rooms and housing facilities appropriate to my gender.

### **Honest Effort:**

- I will learn and follow the rules of my sport.
- I will give my best effort while training and competing.
- I will not hold back during preliminary rounds by playing below my ability level to get placed into an easier division.

### **Well-Being:**

- I will have my Application for Participation current prior to the start of the season.
- I will communicate all changes that may occur on my Application for Participation during any season.

## **COACH/LOCAL PROGRAM VOLUNTEER GUIDELINES**

### **Responsibility For Actions:**

- I will not use my cell phone and any other electronic devices while training and competing unless in an emergency.
- I will ensure my team is aware that they may lose the use of their personal electronic devices for a period of time if used inappropriately (i.e. making a phone call/texting during training and competition).
- I will make sure my team follows instructions while training, competing, and traveling.
- I will chaperone the athletes and unified partners assigned to me.
- I will make sure my team uses locker rooms and housing facilities appropriate to their gender.
- I will make sure my sports knowledge and coaches training is up to date to ensure a positive experience and safety of the athletes.

### **Honest Effort:**

- I will follow the rules of my sport and will educate my team if needed.

- I will ensure that accurate scores are provided for entry into any event.
- I will encourage my team to give their best effort during training and competition.
- I will not encourage my team to hold back during preliminary rounds by playing below their ability level to get placed into an easier division.

**Well-Being:**

- I will make sure that I always have the most up to date copies of Application for Participation forms for my team during each training and competition.
- In cases of severe injury and/or illness (i.e. concussion) I will ensure approval of a certified medical professional before allowing a sick/injured member to resume physical activities.
- I will read and take note of limitations that anyone on my team may have that are included on their Application for Participation.

**SIGN OFF**

- I have read, or have had read to me, both the general guidelines for the SOPA Code of Conduct, as well as the guidelines in regards to my position as an Athlete, Unified Partner, Coach, or Local Program Volunteer. By signing this Code of Conduct, I understand any violations may result in the loss of my eligibility to participate in and attend Special Olympics PA events.
- On behalf of \_\_\_\_\_, I have read and explained to them both the general guidelines for the SOPA Code of Conduct, as well as the guidelines in regards to their position as an Athlete, Unified Partner, Coach, or Local Program Volunteer. By signing this Code of Conduct on their behalf, I understand any violations may result in the loss of their eligibility to participate in and attend Special Olympics PA events.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## Housing Policy

### Safety Statement

Special Olympics is an athlete-centered movement that welcomes all athletes with intellectual disabilities regardless of physical ability to participate in sports training and competition.

Special Olympics is inclusive for all persons with intellectual disabilities over the age of eight and offers a Young Athletes program for individuals with intellectual disabilities under the age of eight.

Special Olympics Pennsylvania (SOPA) is committed to providing appropriate and safe environments for its athletes, volunteers, and employees. The health and safety of the athletes we serve is the highest priority for SOPA. Participants should feel that every Special Olympics event is a safe and positive experience and should not be fearful of other athletes, coaches or volunteers.

Arranging housing for overnight events involves the consideration of a variety of factors, including the varying abilities, ages, maturity, and behaviors of athletes, the availability of housing and the costs associated with overnight accommodations. Risk management principles apply to all aspects of SOPA activities. Although it is not possible to avoid all risks associated with sports training, competition, travel, and other SOPA activities, we must always consider ways to avoid or minimize identifiable risks when practical, including, in housing athletes during overnight events.

SOPA has adopted the following Housing Policy to apply to the housing of SOPA athletes and Unified Partners traveling to overnight events. This Housing Policy (or summary of key elements) will be distributed to and acknowledged by all athletes/Unified Partners and/or their parents or legal guardians as part of the athlete application for participation (commonly called the "athlete medical") at least once every three years. In addition, the latest version of this Policy (or summary of key elements) will be maintained on the SOPA website at [www.specialolympicspa.org](http://www.specialolympicspa.org).

There may be situations, such as World/National Games and competitions sponsored by other state or national Special Olympics Programs, where SOPA does not arrange for the overnight accommodations. In such situations, SOPA will apply the requirements of this Policy to the fullest extent possible given the arrangements for overnight accommodations established by the sponsor for that event. SOPA will make reasonable attempts to notify all athletes/Unified Partners scheduled to participate in the overnight event if any requirement of this Policy cannot be implemented during such event.

This Policy is not intended to, and cannot foresee all possible situations that might arise when attempting to arrange for the housing of athletes, Unified Partners, volunteers, and other chaperones at overnight events sponsored by SOPA or by other state or national Special Olympics Programs. In the event a situation arises that is not specifically provided for in this Policy, a resolution of that situation in keeping with the spirit and other provisions of this Policy will be implemented after appropriate review and approval by SOPA's President and CEO.

### Policy for Housing During Overnight Travel

At times, it may be necessary for athletes/Unified Partners who participate in certain Special Olympics events to travel and stay overnight in housing accommodations (such as hotel/motel/dorm) arranged by Special Olympics. This Policy applies to any overnight accommodations arranged by SOPA, either by the state office or by local Programs if travelling for a local invitational or other event not sponsored by the state office.

The Head of Delegation (HOD) for each SOPA local program is responsible for implementing this Housing Policy at events and ensuring that the volunteers and chaperones are familiar with and carrying out the Policy. This includes pre-event housing assignments as well as managing this policy for late activation of athletes, Unified Partners or volunteers.

The following specific rules will be followed:

1) Requirements prior to attending an overnight event:

- a) All athletes/Unified Partners must complete and sign a "Travel Information" form (if there are any changes from information provided on the Application for Participation form currently on file). This "Travel Information" form will be provided and collected by each local Program HOD prior to travel.
- b) The local SOPA program will make reasonable attempts to inform each adult athlete, each Unified Partner, and the parents or guardian of each minor athlete and each adult athlete unable to consent about the name and age of his or her roommate(s) during the overnight event and the names of the chaperones attending.
- c) All athletes/Unified Partners must acknowledge that they have received and will abide by SOPA's Code of Conduct.
- d) All athletes/Unified Partners, or in the case of minor athletes/Unified Partners and adult athletes unable to consent their parent and/or guardian, must have acknowledged that a copy of SOPA's Athlete Housing Policy has been made available to them.

Note: The requirements of 1 (c) and 1 (d) will be met by the athlete's three-year "Application for Participation" form.

2) Coaches, Volunteers, and Chaperones.

- a) All coaches, volunteers, or other chaperones staying overnight in the same facility with SOPA athletes MUST have an up-to-date Class A Volunteer Form (updated every three years) on file with the SOPA local program office, regardless of whether or not they are staying in a room with an athlete.
- b) A chaperone/athlete ratio of at least one properly registered and screened chaperone to every four athletes must be maintained during overnight events. Proper supervision can be maintained without having a chaperone present in the room at all times.

3) Housing Requirements.

- a) The SOPA local Program's Head of Delegation and/or SOPA state office staff with responsibilities for specific events have the discretion to decide whether an athlete is eligible to participate in overnight events.
- b) Unified Partners will not be assigned to rooms with SOPA athletes.
- c) Athletes, Unified Partners, and volunteers may not share a room with someone of the opposite sex, except as provided below:
  - i) A required one-on-one chaperone who is a parent, guardian or other family-designated adult who has been properly registered and screened (received Class A volunteer screening).
  - ii) Married athletes who are both attending the event as members of a registered delegation. This exception does not apply to the spouse of an athlete who is not participating in the event, but attending solely as a spectator.
  - iii) Married volunteers who are both attending the event as members of a registered delegation. This exception does not apply if one of the volunteers is required to share a room with an athlete except as noted above in 3) c) i) (other than the married couple's child), as this scenario will create a situation whereby an athlete is housed with a

- volunteer of the opposite sex.
- iv) Housing in a facility that has multiple private rooms in addition to living space (such as a condominium or dormitory). Both males and females may be assigned to one condominium, if necessary, but private rooms may not be shared by individuals of the opposite sex. Chaperones must also be housed in the condominium and the chaperone/athlete ratio (as outlined above) must be maintained.
  - v) Use of barracks or other facility (such as a gym) where a large number of individuals are assigned to one room. Athletes and volunteers must be separated as much as possible by gender (for example, females on one side of the gym and males on the other side).
- d) All reasonable efforts will be made to house individuals of appropriate age ranges together.
- i) In order to participate in an overnight event, athletes or Unified Partners under the age of ten (10) must be accompanied by a properly registered and screened parent, guardian, or other family-designated adult individual, who will room with the athlete/Unified Partner for the duration of the overnight event. For purposes of this requirement "properly registered and screened" means the individual has completed Class A volunteer screening.
    - (1) The athlete/Unified Partner and parent, guardian or family-designated adult individual may not stay in the same hotel, motel, or dorm room with other members of the delegation.
    - (2) The arrangement for housing an athlete/Unified Partner under this section with a parent, guardian or family-designated adult individual may not be considered for purposes of determining the delegation's 4:1 athlete to volunteer ratio.
  - ii) Under no circumstances is an athlete/Unified Partner 18 years of age or older permitted to room with an athlete/Unified Partner 13 years of age or younger. When athletes/Unified Partners over 18 years of age are rooming with athletes/Unified Partners under 18 years of age, there shall be no more than a four year age difference between the youngest and oldest of those athletes/Unified Partners. This same four year age differential limitation will be applied in the event a minor coach/volunteer must be roomed with an adult coach/volunteer.
  - iii) To the maximum extent possible, when athletes/Unified Partners between the ages of 10 and 17 will be housed together, they shall be housed such that there is no more than a four year age difference between those athletes/Unified Partners.
- e) All reasonable efforts should be made to house athletes of similar functional abilities together. Local programs must note special needs (wheelchair access, allergies, etc.) when submitting housing requests, and reasonable attempts will be made to accommodate such needs within the constraints of this Policy and the limitations of the facility itself. If any such special needs cannot be met, the local program shall give notice to the athlete(s) affected or, in the case of a minor or adult athlete unable to consent on his/her own, to his other parent or guardian.
- f) If an athlete is required to have one-to-one supervision at an overnight event due to a previously reported incident/action, the athlete and chaperone may not stay in the same hotel, motel, or dorm room with other members of the delegation. The purpose of the one-to-one supervision is to separate the athlete requiring the one-to-one supervision from the delegation for his/her safety and/or the safety of other athletes.
- g) In the event a family or family-designated housing assignment is desired which would otherwise be outside of these Policy requirements, such request from the adult athlete or parent/guardian of minor athlete/Unified Partner or adult athlete unable to consent is to be made in writing.
- 4) Additional Requirements for Housing in Dorms, Hotels, and Motels.

- a) In hotel/motel environments, a maximum of two (2) athletes/Unified Partners under age 18 may share a bed (double size or larger). Athletes/Unified Partners age 18 and older will not share beds. Coaches/volunteers will not share beds, regardless of age.
- b) In situations permitted by paragraph 4 (a), when the number of athletes/Unified Partners assigned to a hotel/motel room exceeds the number of available beds, volunteers should promote the use of sleeping bags, request cots from the hotel/motel, use pull-out beds or couch cushions to fashion additional makeshift beds (if permitted by fire ordinances), and/or use additional bedding in an "over/under" arrangement (with one athlete under the covers and the other on top of the covers with the additional bedding) to maximize potential sleeping arrangements.
- c) In dorms, no one will share beds.
- d) Under no circumstances may a SOPA coach, Unified Partner, volunteer or chaperone be assigned to share a room with an athlete of any age or gender unless the chaperone is a parent, guardian or other family-designated adult of the athlete, and that chaperone has been properly registered and screened (received Class A volunteer screening).

5) Suggestions for providing athlete/Unified Partner housing supervision

General suggestions:

Best efforts should be made to always have at least 2 volunteers present and minimize the likelihood of a volunteer being alone with an athlete. The required 4:1 athlete/coach chaperoning ratio must be maintained at all times (however, as noted in 2(b) above, proper supervision can be maintained without having a chaperone present in the room at all times during overnight events).

Technology is becoming more and more a part of our lives, and appropriate use of cameras, imaging and similar digital devices should be enforced. For example, use of such devices in showers, restrooms, or other areas where privacy is expected by participants is prohibited.

Specific suggestions for various housing situations:

- a) Hotels. Whenever possible, reserve connecting rooms so that chaperones/volunteers have direct access to the athletes'/Unified Partners' room(s). If connecting rooms are not available:
    - i) Ensure that the chaperone has a key to the athletes'/Unified Partners' room(s).
    - ii) Ensure that the athletes /Unified Partners know how to reach the chaperone at all times.
  - b) Condo/Dorm (or other facility with multiple private rooms) – Whenever possible, leave the doors to private rooms open (unlocked) so that chaperones can monitor each room.
  - c) Cabins or Barracks (or other facility with a large number of beds in one room) – Whenever possible, chaperones should be assigned to a location in close proximity to the athletes/Unified Partners he/she is supervising. No less than (2) Class A registered adult chaperones will be assigned to each cabin or barracks regardless of the number of athletes/Unified Partners assigned to the same.
- 6) SOPA will attempt to station medical and security personnel at each housing facility (hotel/motel/dorm) utilized during an event and a specific room(s) will be designated for these personnel. Such personnel may be medical/security professionals or Special Olympics volunteers designated for these roles. In addition, where possible, a SOPA state office staff person will be housed in each of these facilities. Whenever feasible, overnight roaming security patrols will be implemented for delegation safety. Individuals conducting such patrols may be security professionals or Special Olympics volunteers designated for this role.

**SIGN OFF**

- I have read, or have had read to me, both the general guidelines for the SOPA Housing Policy, as well as the guidelines in regards to my position as an Athlete, Unified Partner, Coach, or Local Program Volunteer. By signing this Housing Policy, I understand and agree to all the policies outlined above.
- On behalf of \_\_\_\_\_, I have read and explained to them both the general guidelines for the Housing Policy, as well as the guidelines in regards to their position as an Athlete, Unified Partner, Coach, or Local Program Volunteer. By signing this Housing Policy, I understand and agree to all the policies outlined above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



# Athlete Medical Form – HEALTH HISTORY

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



Athlete First & Last Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Athlete Date of Birth (dd/mm/yyyy): \_\_\_\_\_  Female  Male

COUNTRY: \_\_\_\_\_ Email: \_\_\_\_\_

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

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Autism                                | <input type="checkbox"/> Down Syndrome          | <input type="checkbox"/> Fragile X Syndrome |
| <input type="checkbox"/> Cerebral Palsy                        | <input type="checkbox"/> Fetal Alcohol Syndrome |   |
| <input type="checkbox"/> 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):

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Brace                 | <input type="checkbox"/> Colostomy          | <input type="checkbox"/> Communication |
| <input type="checkbox"/> Device/C-PAP Machine  | <input type="checkbox"/> Crutches or Walker | <input type="checkbox"/> Dentures      |
| <input type="checkbox"/> Glasses or Contacts   | <input type="checkbox"/> G-Tube or J-Tube   | <input type="checkbox"/> Hearing       |
| <input type="checkbox"/> Aid/Implanted Device  | <input type="checkbox"/> Inhaler            | <input type="checkbox"/> Pacemaker     |
| <input type="checkbox"/> Removable Prosthetics | <input type="checkbox"/> Splint             | <input type="checkbox"/> 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	<input type="checkbox"/> No <input type="checkbox"/> Yes	Depression (diagnosed)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Aggressive behavior during the past year	<input type="checkbox"/> No <input type="checkbox"/> Yes	Anxiety (diagnosed)	<input type="checkbox"/> No <input type="checkbox"/> 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



Athlete's First and Last Name: \_\_\_\_\_

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

Loss of Consciousness	<input type="checkbox"/> No <input type="checkbox"/> Yes	High Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	Stroke/TIA	<input type="checkbox"/> No <input type="checkbox"/> Yes
Dizziness during or after exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes	High Cholesterol	<input type="checkbox"/> No <input type="checkbox"/> Yes	Concussions	<input type="checkbox"/> No <input type="checkbox"/> Yes
Headache during or after exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes	Vision Impairment	<input type="checkbox"/> No <input type="checkbox"/> Yes	Asthma	<input type="checkbox"/> No <input type="checkbox"/> Yes
Chest pain during or after exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hearing Impairment	<input type="checkbox"/> No <input type="checkbox"/> Yes	Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Shortness of breath during or after exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes	Enlarged Spleen	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hepatitis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Irregular, racing or skipped heart beats	<input type="checkbox"/> No <input type="checkbox"/> Yes	Single Kidney	<input type="checkbox"/> No <input type="checkbox"/> Yes	Urinary Discomfort	<input type="checkbox"/> No <input type="checkbox"/> Yes
Congenital Heart Defect	<input type="checkbox"/> No <input type="checkbox"/> Yes	Osteoporosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Spina Bifida	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Attack	<input type="checkbox"/> No <input type="checkbox"/> Yes	Osteopenia	<input type="checkbox"/> No <input type="checkbox"/> Yes	Arthritis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Cardiomyopathy	<input type="checkbox"/> No <input type="checkbox"/> Yes	Sickle Cell Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Heat Illness	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Valve Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Sickle Cell Trait	<input type="checkbox"/> No <input type="checkbox"/> Yes	Broken Bones	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Murmur	<input type="checkbox"/> No <input type="checkbox"/> Yes	Easy Bleeding	<input type="checkbox"/> No <input type="checkbox"/> Yes	Dislocated Joints	<input type="checkbox"/> No <input type="checkbox"/> Yes
Endocarditis	<input type="checkbox"/> No <input type="checkbox"/> 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	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Numbness or tingling in legs, arms, hands or feet	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Weakness in legs, arms, hands or feet	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Head Tilt	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Spasticity	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Paralysis	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> 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: \_\_\_\_\_

## 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 <sub>2</sub> Sat	Blood Pressure (in mmHg)		Vision		
cm	kg	BMI	C			BP Right:	BP Left:	Right Vision 20/40 or better <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A		
in	lbs	Body Fat %	F					Left Vision 20/40 or better <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A		

  

Right Hearing (Finger Rub) <input type="checkbox"/> Responds <input type="checkbox"/> No Response <input type="checkbox"/> Can't Evaluate	Bowel Sounds <input type="checkbox"/> Yes <input type="checkbox"/> No
Left Hearing (Finger Rub) <input type="checkbox"/> Responds <input type="checkbox"/> No Response <input type="checkbox"/> Can't Evaluate	Hepatomegaly <input type="checkbox"/> No <input type="checkbox"/> Yes
Right Ear Canal <input type="checkbox"/> Clear <input type="checkbox"/> Cerumen <input type="checkbox"/> Foreign Body	Splenomegaly <input type="checkbox"/> No <input type="checkbox"/> Yes
Left Ear Canal <input type="checkbox"/> Clear <input type="checkbox"/> Cerumen <input type="checkbox"/> Foreign Body	Abdominal Tenderness <input type="checkbox"/> No <input type="checkbox"/> RUQ <input type="checkbox"/> RLQ <input type="checkbox"/> LUQ <input type="checkbox"/> LLQ
Right Tympanic Membrane <input type="checkbox"/> Clear <input type="checkbox"/> Perforation <input type="checkbox"/> Infection <input type="checkbox"/> NA	Kidney Tenderness <input type="checkbox"/> No <input type="checkbox"/> Right <input type="checkbox"/> Left
Left Tympanic Membrane <input type="checkbox"/> Clear <input type="checkbox"/> Perforation <input type="checkbox"/> Infection <input type="checkbox"/> NA	Right upper extremity reflex <input type="checkbox"/> Normal <input type="checkbox"/> Diminished <input type="checkbox"/> Hyperreflexia
Oral Hygiene <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	Left upper extremity reflex <input type="checkbox"/> Normal <input type="checkbox"/> Diminished <input type="checkbox"/> Hyperreflexia
Thyroid Enlargement <input type="checkbox"/> No <input type="checkbox"/> Yes	Right lower extremity reflex <input type="checkbox"/> Normal <input type="checkbox"/> Diminished <input type="checkbox"/> Hyperreflexia
Lymph Node Enlargement <input type="checkbox"/> No <input type="checkbox"/> Yes	Left lower extremity reflex <input type="checkbox"/> Normal <input type="checkbox"/> Diminished <input type="checkbox"/> Hyperreflexia
Heart Murmur (supine) <input type="checkbox"/> No <input type="checkbox"/> 1/6 or 2/6 <input type="checkbox"/> 3/6 or greater	Abnormal Gait <input type="checkbox"/> No <input type="checkbox"/> Yes, describe below
Heart Murmur (upright) <input type="checkbox"/> No <input type="checkbox"/> 1/6 or 2/6 <input type="checkbox"/> 3/6 or greater	Spasticity <input type="checkbox"/> No <input type="checkbox"/> Yes, describe below
Heart Rhythm <input type="checkbox"/> Regular <input type="checkbox"/> Irregular	Tremor <input type="checkbox"/> No <input type="checkbox"/> Yes, describe below
Lungs <input type="checkbox"/> Clear <input type="checkbox"/> Not clear	Neck & Back Mobility <input type="checkbox"/> Full <input type="checkbox"/> Not full, describe below
Right Leg Edema <input type="checkbox"/> No <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+	Upper Extremity Mobility <input type="checkbox"/> Full <input type="checkbox"/> Not full, describe below
Left Leg Edema <input type="checkbox"/> No <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+	Lower Extremity Mobility <input type="checkbox"/> Full <input type="checkbox"/> Not full, describe below
Radial Pulse Symmetry <input type="checkbox"/> Yes <input type="checkbox"/> R>L <input type="checkbox"/> L>R	Upper Extremity Strength <input type="checkbox"/> Full <input type="checkbox"/> Not full, describe below
Cyanosis <input type="checkbox"/> No <input type="checkbox"/> Yes, describe	Lower Extremity Strength <input type="checkbox"/> Full <input type="checkbox"/> Not full, describe below
Clubbing <input type="checkbox"/> No <input type="checkbox"/> Yes, describe	Loss of Sensitivity <input type="checkbox"/> No <input type="checkbox"/> 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:
- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Concerning Cardiac Exam       | <input type="checkbox"/> Acute Infection                  | <input type="checkbox"/> O <sub>2</sub> Saturation Less than 90% on Room Air |
| <input type="checkbox"/> Concerning Neurological Exam  | <input type="checkbox"/> Stage II Hypertension or Greater | <input type="checkbox"/> Hepatomegaly or Splenomegaly                        |
| <input type="checkbox"/> Other, please describe: _____ |   |  |

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

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Follow up with a cardiologist      | <input type="checkbox"/> Follow up with a neurologist        | <input type="checkbox"/> Follow up with a primary care physician      |
| <input type="checkbox"/> Follow up with a vision specialist | <input type="checkbox"/> Follow up with a hearing specialist | <input type="checkbox"/> Follow up with a dentist or dental hygienist |
| <input type="checkbox"/> Follow up with a podiatrist        | <input type="checkbox"/> Follow up with a physical therapist | <input type="checkbox"/> Follow up with a nutritionist                |
| <input type="checkbox"/> Other/Exam Notes: _____            |  |   |

<b>Signature of Licensed Medical Examiner</b>	Name: _____
	E-mail: _____
	Phone: _____
	License #: _____
Exam Date	

# Athlete Medical Form – MEDICAL REFERRAL FORM

(To be completed by a Licensed Medical Professional only if referral is needed)



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       O<sub>2</sub> 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