ATHLETE REGISTRATION PACKET

Special Olympics
Maine

Dear Special Olympics Athletes, Parents, and Guardians:

Through the power of sports, people with intellectual disabilities discover new strengths and abilities, skills and success. Our athletes find joy, confidence and fulfillment — on the playing field and in life. They also inspire people in their communities and elsewhere to open their hearts to a wider world of human talents and potential.

To register to become a Special Olympics athlete, please complete the enclosed forms:

- ☐ **ATHLETE RELEASE FORM.** The Athlete Release form was recently updated (January 2017) and we now require all athletes (new/current) to submit/resubmit the new Athlete Release form by December 31st, 2017. Please read the form in its entirety, print the athlete's name, sign, and date accordingly. The new Athlete Release forms will remain current until an updated form is made available. (It is recommended that all athletes complete and submit the new Athlete Release form prior to their next competition).

- ☐ **ATHLETE MEDICAL FORM.** The Special Olympics Athlete Medical Form is designed to identify health concerns that are more common among people with intellectual disabilities. Page 1 Demographics and Health History sections on page 1 may be completed by Parent/Caregiver. Page 2 of the Athlete Medical Form must be completed and signed by a medical professional. Athlete Medical forms must be submitted every three year, from the date of the medical professional's signature, unless Athlete medical information has changed since last submitted medical.

- ☐ **ATHLETE EMERGENCY CARE REFUSAL FORM.** Only complete this form if the athlete does not consent to emergency medical care on religious or other grounds.

- ☐ **ALL ATHLETES MUST ADHERE TO ATHLETE CODE OF CONDUCT.** Review Athlete Code of Conduct at www.somaine.org//wp-content/uploads/2015/02/Athletes-Code-of-Conduct.pdf

The Release Form and the Athlete Medical Form instruct you to complete additional forms in certain uncommon situations. If this applies to you or if you have any other questions, please contact Special Olympics Maine at 207-879-0489.

Please submit completed Athlete Registration forms (original) to:

- BY EMAIL: mikel@somaine.org
- FX: 1-888-490-0672
- BY MAIL: Special Olympics Maine, 125 John Roberts Rd #5, South Portland, ME 04106

Recommendation: Make 2 copies of the completed original Athlete Registration forms:

1. Originals – send to SOMaine State office (see above)
2. Copy 1 – send to Head Coach of Athlete's Delegation
3. Copy 2 – Safekeeping. Keep an extra copy somewhere safe in case original is misplaced.

Thank you. We are excited you are part of the Special Olympics Maine Movement!

ATHLETE RELEASE FORM

Special Olympics
Maine

I want to take part in Special Olympics and agree to the following:

1. **Able to Participate.** I am able to take part in Special Olympics. I know there is a risk of injury.

2. **Photo Release.** Special Olympics organizations may use my picture, video, name, voice, and words to promote Special Olympics.

3. **Overnight Stay.** For some events, I may stay in a hotel or someone's home. Review SOMaine's Athlete Housing Policy. If I have questions, I will ask.

4. **Emergency Care.** I consent to medical care if needed in an emergency, unless I check one of these boxes:

   ☐ I have a religious or other objection to receiving medical treatment.
   ☐ I consent to emergency medical care, but I do not consent to blood transfusions.
   (If either box is checked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)

5. **Health Programs.** If I take part in a health program, I consent to health activities, exams, and treatment. This should not replace regular health care. I can say no to treatment or anything else any time.

6. **Personal Information.** I understand my information may be used and shared by Special Olympics to:
   - Make sure I am eligible and can participate safely;
   - Run trainings and events and share results;
   - Put my information in a computer system;
   - Provide health treatment, make referrals, consult doctors, and remind me about follow-up services;
   - Research, share, and respond to needs of Special Olympics athletes (identifying information removed if shared publically); and
   - Protect health and safety, respond to government requests, and report information required by law.

   I can ask to see and change my information. I can ask to limit how my information is used.

7. **Concussions.** I understand the risk of concussions and continuing to play sports with a concussion. I may have to get medical care if I have a suspected concussion. I also may have to wait 7 days or more and get permission from a doctor before I start playing sports again.

ATHLETE NAME: ____

ATHLETE SIGNATURE (required if over 18 years old and signing on own behalf)

I have read and understand this release. If I have questions, I will ask. By signing, I agree to this form.

Participant Signature: ____ Date: _______________________________

PARENT/GUARDIAN SIGNATURE (required if under 18 years old or has a legal guardian)

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: ________________________

ATHLETE MEDICAL FORM Page 1 of 2

DEMOGRAPHICS

Delegation: ______________________________

Athlete s Social Security # ________ - ________ - ________ (if US Citizen)

☐ Male
☐ Female

Date of Birth (month/day/year) _____/_____/_____

Athlete s Name ______________________________

Athlete s Address ______________________________
____

Athlete s Home Phone # ______________

Parent/Guardian s Name ______________________________

Parent s Work Phone # ______________

Parent/Guardian s Address (if different than athlete) ______________________________
____

Parent s Home Phone # ______________

Emergency Contact (if other than parent/guardian) ______________________________

Emergency Contact s Phone # ______________

Health/Accident Insurance Company ______________________________

Policy # ______________

HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER

Yes	No	
☐	☐	*Heart disease / heart defect / high blood pressure
☐	☐	*Chest pain
☐	☐	*Seizures / epilepsy/fainting spells
☐	☐	*Diabetes
☐	☐	*Concussion or serious head injury
☐	☐	*Major surgery or serious illness
☐	☐	Heat stroke / exhaustion
☐	☐	*Blindness / visual problem
☐	☐	Contact lenses / glasses
☐	☐	Hearing loss / hearing aid
☐	☐	Bone or joint problem

Yes	No	
☐	☐	Allergy:
☐	☐	Medicines: ______________
☐	☐	Food: ______________
☐	☐	Insect stings/bites: ______________
☐	☐	Special diet
☐	☐	*Asthma
☐	☐	Tobacco use
☐	☐	Easy bleeding
☐	☐	Emotional / psychiatric / behavioral
☐	☐	Sickle cell trait or disease
☐	☐	Immunizations up to date
☐	☐	Other ______________

Date of most recent tetanus immunization ______/_____/_____

(*) Requires physical examination

Medications:
Please print medication name, amount, date prescribed and number of times per day medication is given.

Medication Name	Dosage	Date Prescribed.	Times per day	Medication Name	Dosage	Date Prescribed.	Times per day

Signature of parent/caregiver/adult athlete: ______________________________ date _____/_____/_____

ATHLETE MEDICAL FORM Page 2 of 2

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 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: 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).

Yes	No	
☐	☐	Has an x-ray evaluation for atlanto-axial instability been done?
☐	☐	If yes, was it positive for atlanto-axial instability? (positive indicates that the atlanto-dens interval is 5mm or more)

PHYSICAL EXAMINATION

Blood pressure: _____/_____ Weight: _____ Height: _____

Normal	Abnormal		Normal	Abnormal		Normal	Abnormal	
☐	☐	Vision	☐	☐	Cardiovascular system	☐	☐	Cranial nerves
☐	☐	Hearing	☐	☐	Respiratory system	☐	☐	Coordination
☐	☐	Oral cavity	☐	☐	Gastrointestinal system	☐	☐	Reflexes
☐	☐	Neck	☐	☐	Genitourinary system			
☐	☐	Extremities	☐	☐	Skin			

Other: ____________________

Primary MR Etiology/Category: (If known) ____________________

I have reviewed the above health information and have performed 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: ____________________

____________________ PHONE: ____________________

ATLANTO-AXIAL INSTABILITY (AAI) SPECIAL RELEASE FORM

(SPECIAL RELEASE CONCERNING SPINAL CORD COMPRESSION AND ATLANTO-AXIAL INSTABILITY)

Instructions: Only complete this form if symptoms of spinal cord compression or Atlanto-axial instability were found in a pre-participation examination and a doctor then provided clearance for participation following a neurological evaluation.

I agree to the following:

1. **Spinal Cord Compression Symptoms.** In a pre-participation examination, a licensed medical professional found symptoms that might be the result of spinal cord compression or Atlanto-axial instability.
2. **Neurological Evaluation.** After a neurological evaluation, a qualified doctor concluded that:
   - The cause of the symptoms will not result in additional risk of neurological injury due to participation in sports, and
   - Participation in Special Olympics activities is safe without restrictions or with restrictions that will be shared with Special Olympics and followed.
3. **Liability Release.** I acknowledge that I have been informed of the findings and determinations of the physician. I release and hold harmless Special Olympics from all claims in connection with possible spinal cord compression or Atlanto-axial instability.

ATHLETE NAME: ____

ATHLETE SIGNATURE (required if Athlete is over 18 years old and is signing on own behalf)

I have read and understand this release. By signing, I agree to this release.

Athlete Signature: ____ Date: ______________________________

PARENT/GUARDIAN SIGNATURE (required if Athlete is under 18 years old or has a legal guardian)

I am a parent or guardian of the Athlete and am authorized to enter into this release on the Athlete's behalf. I have read and understand this release and have explained the contents to the Athlete as appropriate. By signing, I agree to this release 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.

Parent/Guardian Signature: ____ Date: ______________________________

Printed Name: ____ Relationship: _______________________________

Special Olympics Maine

EMERGENCY MEDICAL CARE REFUSAL FORM – ATHLETE COMPLETION
(To be completed by athlete signing on own behalf)

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

I, ____, am at least 18 years old 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 CHECK 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 Special Olympics 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 agree that I will be accompanied by an adult friend or family member at all times during my participation in any Special Olympics activity, so that this person can take personal responsibility for me during a medical emergency where I am unable to speak for myself. I understand that if this friend or family member is not present at all times, I will not be permitted to participate in Special Olympics activities, and that no exceptions will be made.

4. **No Guarantee.** I understand that Special Olympics cannot guarantee that emergency medical care will be withheld 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.

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 directing Special Olympics not to do so on religious or other grounds.

I have read and understand this release. By signing, I agree to this release.

Athlete Signature: ____ Date: ________________________________

By signing, I agree to accompany the Athlete during all 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.

Signature of Accompanying Adult: ______________________________________ Date: ________________________________

Printed Name: ____ Relationship: __________________________