Special Olympics New Hampshire
650 Elm Street
Manchester, NH 03101
www.sonh.org

Medical Form and Application For Athlete Participation in Special Olympics New Hampshire

Local Program Name: _____

T-shirt Size _____ Sex: ❑ Male ❑ Female Date of Birth ____/____/____

Athlete Name _____ Home Phone _____

Home Address _____ Work Phone _____

_____ Home Email _____

Parent/Guardian Name _____ Relationship to Athlete _____

Address *(If different than athlete)* _____

Parent/Guardian: Please check if you do not wish to receive mailings from SONH: ❑

Emergency Contact/Relationship _____/_____ Primary Phone _____

Health/Accident Insurance Company _____ Policy No. _____

SECTION A - Athlete Health Information

❑Yes ❑No 1. Heart Disease/Heart Defect/High Blood Pressure
❑Yes ❑No 2. Chest Pain or Fainting Spells
❑Yes ❑No 3. Seizures/Epilepsy
❑Yes ❑No 4. Diabetes
❑Yes ❑No 5. Down syndrome
❑Yes ❑No *- Have cervical spine (neck bone) x-rays been done?*
❑Yes ❑No *- Atlano Axial Instability*
❑Yes ❑No 6. Parent/Sibling (Under 40) Died of Heart Disease
❑Yes ❑No 7. Absence of Vision/Blind in One Eye
❑Yes ❑No 8. Absence of One Kidney or Testicle
❑Yes ❑No 9. Concussion or Serious Head Injury
❑Yes ❑No 10. Major Surgery or Serious Illness
❑Yes ❑No 11. Heat Stroke/Exhaustion
❑Yes ❑No 12. Other Problems that would interfere with sports participation: _____

Comments: _____

❑Yes ❑No 13. Uses Wheelchair
❑Yes ❑No 14. Impaired Motor Ability
❑Yes ❑No 15. Allergy to the Following *(list specific)*
Medicine _____
Foods _____
Insect Sting/Bite _____
❑Yes ❑No 16. Special Diet
❑Yes ❑No 17. Exercise-Induced Wheezing
❑Yes ❑No 18. Tendency to Bleed Easily
❑Yes ❑No 19. Emotional/Psychiatric/Behavioral Problems
❑Yes ❑No 20. Serious Bone or Joint Disorder
❑Yes ❑No 21. Sickle Cell Trait or Disease
❑Yes ❑No 22. Hearing Aid/Hearing Loss
❑Yes ❑No 23. Contact Lenses/Eyeglasses
❑Yes ❑No 24. Dentures/False Teeth
❑Yes ❑No 25. Immunizations (shots) are up to date
26. Date of Last Tetanus Shot ____/____/____

Medications – Please print medication name, dosage, date prescribed and number of times per day medication is taken.

Medication Name	Dosage	Date Prescribed	Times per Day

Signature (Adult Athlete or Parent/Guardian) _____ **Date** ____/____/____

SECTION B – Medical Certification

A physical examination performed by a licensed examiner (medical doctor, physician's assistant or nurse practitioner) is required for participation every three years.

Note: If the athlete has Down syndrome, Special Olympics requires a full radiological examination once to establish the absence of Atlanto-Axial Instability before he/she may participate in sports 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 radiological examination is required are: equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, squat lift and soccer team competition.

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

❑ Restrictions _____ **Date** ____/____/____

Examiner's Name _____ **Signature** _____ **Phone** _____

Address _____

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New Hampshire
650 Elm Street
Manchester, NH 03101
www.sonh.org

Official Special Olympics Athlete Consent Form & Consent to Participate in Healthy Athlete Screenings

Consent to Be Completed by ADULT ATHLETE

I, _____ 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 examiner (medical doctor, physician's assistant or nurse practitioner) has reviewed the health information and 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 have had a one-time full radiological examination which establishes the absence of Atlanto-Axial Instability. I am aware that I must have this radiological examination before I can participate in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, and soccer.

Special Olympics has my permission (both during and anytime after) to use my likeness, name, voice, or words in either 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 those 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 the 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 understand that by signing below I consent to participate in the **Special Olympics Healthy Athletes Program** that provides individuals screening assessments of health status and health care needs in the areas of vision; oral health; hearing; physical therapy; and a variety of health promotion areas. I understand there is no obligation for me to participate in the **Healthy Athlete Program** and that I may decide not to participate. Provision of these health services is not intended as a substitute for regular care. I also understand that I should seek my own independent medical advice and assistance regardless of the provisions of these services and that Special Olympics is not through the provisions of these services responsible for my health.

I, the athlete named above, have read and fully understand the provisions of 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 understand this release and has agreed to its terms.

Name (please print) _____

Relationship to athlete (family member, teacher, coach, etc.) _____

Consent to Be Completed by PARENT OR GUARDIAN OF MINOR ATHLETE

I am the parent/ guardian of, _____ the minor 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

I represent and warrant that, to the best of my knowledge and belief, the athlete is physically and mentally able to participate in Special Olympics activities. I also represent that a licensed examiner (medical doctor, physician's assistant or nurse practitioner) has reviewed the health information and contained in the athletes application and has certified, based on an independent medical examination, that there is no medical evidence which would preclude the athlete from participating in Special Olympics. 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 my neck or upper spine unless he/she has had a one-time full radiological examination which establishes the absence of Atlanto-Axial Instability. I am aware that I must have this radiological examination before I can participate in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, and soccer.

In permitting the athlete to participate, I am specifically granting my permission (both during and anytime after) to use the athletes likeness likeness, name, voice, or words in either 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 those purposes and activities.

If a medical emergency should arise during the athlete's participation in any Special Olympic activities, at a time when I am not personally present to be consulted regarding the athlete's care, I hereby authorize Special Olympics, on my behalf, to take whatever measures are necessary to ensure 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 understand that by signing below I consent to participate in the **Special Olympics Healthy Athletes Program** that provides individuals screening assessments of health status and health care needs in the areas of vision; oral health; hearing; physical therapy; and a variety of health promotion areas. I understand there is no obligation for me to participate in the **Healthy Athlete Program** and that I may decide not to participate. Provision of these health services is not intended as a substitute for regular care. I also understand that I should seek my own independent medical advice and assistance irrespective of the provisions of these services and that Special Olympics is not through the provisions of these services responsible for my health.

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 the provisions to the athlete. Through my signature on this release form, I am agreeing to the above provisions on my own behalf and on behalf of the athlete.

Signature of Parent of Guardian _____ Date _____

Local Program Name _____