Medical / Release Form

Each participant MUST have a current medical / release form on file with Special Olympics Kansas, 5280 Foxridge Drive, Mission, Kansas 66202 and in the possession of the coach prior to participating in any event/training/competition.

DEMOGRAPHICS

TEAM NAME: _____ NUMBER: _____

Athlete's Name _____ ☐ Male ☐ Female Date of Birth (month/day/year) _____/_____/_____

Athlete's Address _____ Athlete Home Phone # ( ) _____

City: _____ State: _____ Zip: _____ Parent Email Address _____

Parent/Guardian's Name _____ Parent Primary Phone # ( ) _____

Parent/Guardian's Address (if different than athlete) _____ Parent Cell/Alternate Phone# ( ) _____

_____ Parent Employer _____

Emergency Contact (if other than parent/guardian) _____ Emergency Phone #/Cell ( ) _____

Health/Accident Insurance Company _____ Policy # _____

PARTICIPATION AND CONSENT TO TREATMENT: I hereby give permission for the participant named above to participate. To the best of my knowledge, the athlete is physically and mentally able to participate and full disclosure of the participant's medical history has been made to the physician whose signature appears below.
I acknowledge that the participant will be using facilities at his own risk and said parent/guardian, on his behalf, hereby releases, discharges and indemnifies from all liability for alleged injury to person or damage to property of himself and applicant.
I hereby irrevocably grant permission to record the above participant's likeness and/or voice for use by television, films, radio or printed media to further the aims of Special Olympics.
If I am not personally present at activities, in case of necessity, you are authorized, on my behalf and at my account, to take such measures and arrange for such medical and hospital treatment as you may deem advisable for the health and well-being of the participant.

HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER

Yes	No		Yes	No	
☐	☐	*Heart disease / heart defect / high blood pressure	☐	☐	Allergy:
☐	☐	*Chest pain	☐	☐	Medicines: _____
☐	☐	*Seizures / epilepsy/fainting spells	☐	☐	Food: _____
☐	☐	*Diabetes	☐	☐	Insect stings/bites: _____
☐	☐	*Concussion or serious head injury	☐	☐	Special diet
☐	☐	*Major surgery or serious illness	☐	☐	Tobacco use
☐	☐	*Blindness / visual problem	☐	☐	Easy bleeding
☐	☐	*Asthma	☐	☐	Emotional / psychiatric / behavioral
☐	☐	Heat stroke / exhaustion	☐	☐	Sickle cell trait or disease
☐	☐	Contact lenses / glasses	☐	☐	Immunizations up to date
☐	☐	Hearing loss / hearing aid	☐	☐	Wheelchair
☐	☐	Bone or joint problem	☐	☐	Other (for additional space, use back of form): _____

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

NOTE: If there is any significant change in the athlete's health, the athlete's condition ***should*** be reviewed by a physician before further participation.

PARENT / GUARDIAN / ADULT PARTICIPANT SIGNATURE _____

DOWN SYNDROME: ☐ **YES** ☐ **NO** **CHECK ONE: ATLANTO-AXIAL** ☐ **NEG.** ☐ **POS.**

<u>NOTE</u>: If the athlete has Down syndrome, <u>requires</u> that the athlete have a full radiological examination establishing the degree, if any, of Atlanto-Axial instability before he / she may participate in any sport or event. Down syndrome forms are available from office.

MEDICAL CERTIFICATION

A physical examination can only be conducted by a Medical Doctor (MD), Doctor of Osteopathy (DO), Doctor of Chiropractic (DC), Physician's Assistant, or an Advanced Registered Nurse Practitioner (ARNP).

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.

RESTRICTIONS: _____

EXAMINER'S SIGNATURE: _____ **DATE** _____/_____/_____

EXAMINER'S NAME: _____

ADDRESS: _____

_____ **PHONE:** ( ) _____