

# application for participation in special olympics

Please print clearly and complete all sections in their entirety.

**This application expires three (3) years from the date of exam.**

People are eligible for Special Olympics provided they are age 8 or above and are considered to have an intellectual disability or closely related developmental disability, defined as functional limitations in both general learning and two or more adaptive skill areas: communication, leisure, self-direction, home living, community use, work, health and safety, academics, self-care and social skills.

<b>State Office ONLY:</b>	
<b>Delegation:</b>	
_____	
<input type="checkbox"/>	Updated Form
<input type="checkbox"/>	New Athlete
	<input type="checkbox"/> in GMS
	<input type="checkbox"/> not in GMS

## section a: demographics

Delegation: <u>  Mankato LEEP  </u>	Area (1-12, if known): <u>  9  </u>
Athlete Name: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female   Date of Birth (month/date/year): ____/____/____
Athlete Address: _____	Athlete Home Phone: (____) _____
City: _____ State: _____ Zip: _____	Athlete E-mail: _____
Parent/Guardian Name: _____	Parent Home Phone: (____) _____
Parent/Guardian Address (if different than athlete): _____	Parent Work Phone: (____) _____
City: _____ State: _____ Zip: _____	Parent E-mail: _____
Emergency Contact (if other than Parent/Guardian): _____	Emergency Contact Phone: (____) _____
Health/Accident Insurance Company: _____	Policy #: _____

## section b: health history (may be completed by parent/caregiver)

please indicate "yes" or "no" for all areas

<table style="width: 100%; border: none;"> <tr><td><b>Yes</b></td><td><b>No</b></td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Allergies:</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Food:</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Stings/Bites:</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Medicine:</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Asthma</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Blindness/Visual Problems (other than corrective lenses)</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Bone or Joint Problem</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Chest Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Concussion or Serious Head Injury</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Contact Lenses/Glasses</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Diabetes</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Down syndrome (If "Yes", note Section D on reverse side)</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Easy Bleeding</td></tr> </table>	<b>Yes</b>	<b>No</b>		<input type="checkbox"/>	<input type="checkbox"/>	Allergies:	<input type="checkbox"/>	<input type="checkbox"/>	Food:	<input type="checkbox"/>	<input type="checkbox"/>	Stings/Bites:	<input type="checkbox"/>	<input type="checkbox"/>	Medicine:	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Blindness/Visual Problems (other than corrective lenses)	<input type="checkbox"/>	<input type="checkbox"/>	Bone or Joint Problem	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Concussion or Serious Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	Contact Lenses/Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Down syndrome (If "Yes", note Section D on reverse side)	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bleeding	<table style="width: 100%; border: none;"> <tr><td><b>Yes</b></td><td><b>No</b></td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Emotional/Psychiatric/Behavioral Problems</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hearing Loss/Hearing Aid</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Heart Disease/Heart Defect/High Blood Pressure</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Heat Stroke/Exhaustion</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Immunizations up-to-date</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Major Surgery or Serious Illness</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Non-verbal</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Seizures/Epilepsy/Fainting Spells</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Sickle Cell Trait or Disease</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Special Diet</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Uses Tobacco</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Uses Wheelchair</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Other (for additional space, please see reverse side):</td></tr> </table>	<b>Yes</b>	<b>No</b>		<input type="checkbox"/>	<input type="checkbox"/>	Emotional/Psychiatric/Behavioral Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss/Hearing Aid	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease/Heart Defect/High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heat Stroke/Exhaustion	<input type="checkbox"/>	<input type="checkbox"/>	Immunizations up-to-date	<input type="checkbox"/>	<input type="checkbox"/>	Major Surgery or Serious Illness	<input type="checkbox"/>	<input type="checkbox"/>	Non-verbal	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy/Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Trait or Disease	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet	<input type="checkbox"/>	<input type="checkbox"/>	Uses Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	Uses Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	Other (for additional space, please see reverse side):
<b>Yes</b>	<b>No</b>																																																																																				
<input type="checkbox"/>	<input type="checkbox"/>	Allergies:																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Food:																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Stings/Bites:																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Medicine:																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Asthma																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Blindness/Visual Problems (other than corrective lenses)																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Bone or Joint Problem																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Concussion or Serious Head Injury																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Contact Lenses/Glasses																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Down syndrome (If "Yes", note Section D on reverse side)																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Easy Bleeding																																																																																			
<b>Yes</b>	<b>No</b>																																																																																				
<input type="checkbox"/>	<input type="checkbox"/>	Emotional/Psychiatric/Behavioral Problems																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss/Hearing Aid																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease/Heart Defect/High Blood Pressure																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Heat Stroke/Exhaustion																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Immunizations up-to-date																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Major Surgery or Serious Illness																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Non-verbal																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy/Fainting Spells																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Trait or Disease																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Special Diet																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Uses Tobacco																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Uses Wheelchair																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Other (for additional space, please see reverse side):																																																																																			

Date of most recent tetanus immunization: \_\_\_\_/\_\_\_\_/\_\_\_\_

Medications:  None    Listed Below

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

**Signature of Parent/Caregiver (required):** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Are Sections A & B complete? If yes, proceed to reverse side.

## section c: physical examination

must be completed by a licensed medical practitioner

Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Normal	Abnormal		Normal	Abnormal		Normal	Abnormal	
<input type="checkbox"/>	<input type="checkbox"/>	Vision	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular system	<input type="checkbox"/>	<input type="checkbox"/>	Cranial nerves
<input type="checkbox"/>	<input type="checkbox"/>	Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory system	<input type="checkbox"/>	<input type="checkbox"/>	Coordination
<input type="checkbox"/>	<input type="checkbox"/>	Oral cavity	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal system	<input type="checkbox"/>	<input type="checkbox"/>	Reflexes
<input type="checkbox"/>	<input type="checkbox"/>	Neck	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary system			
<input type="checkbox"/>	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Skin			

Other: \_\_\_\_\_

Primary MR Etiology/Category (if known): \_\_\_\_\_

**Yes**     **No**    Does this athlete have Down syndrome? If yes, Section D must be completed. If no, skip to Section E.

**Yes**    I have reviewed the above health information and have performed the above examination on this athlete within the past six (6) months and certify that the athlete can participate in Special Olympics.

Restrictions: \_\_\_\_\_

**THE EXAMINER'S SIGNATURE AND DATE OF EXAM BELOW ARE REQUIRED INFORMATION FOR SECTION C OF THIS APPLICATION TO BE COMPLETE. IF SUBMITTING AN ELECTRONICALLY GENERATED FORM, IT MUST CONTAIN INDICATION OF AN ELECTRONIC SIGNATURE AND THE CONTACT INFORMATION BELOW.**

**Examiner's Signature:** \_\_\_\_\_ **Date of Exam:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Examiner's Name: \_\_\_\_\_

Address (City, State, Zip): \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

## section d: 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: equestrian sports, gymnastics, diving, pentathlon, butterfly stroke and diving starts in swimming, high jump, alpine skiing, snowboarding, squat lift and soccer.

- Yes**    **No**
- Does the athlete participate in a restricted sport or event? If yes or unknown, an x-ray for atlanto-axial instability must be done.
- Has an x-ray evaluation for atlanto-axial instability been done?
- If yes, was the x-ray positive for atlanto-axial instability? Positive indication is the atlanto-dens interval is 5mm or more.

## section e: additional information

Please list any additional information that may be helpful to know about this athlete: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# official special olympics consent form

Delegation: Mankato LEEP Area: 9  
Athlete Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

## section a: consent to be completed by adult athlete

- I, \_\_\_\_\_, am at least 18 years old and am my own legal guardian. **Please complete Section A only.**  
 I, \_\_\_\_\_, am at least 18 years old, but am **NOT** my legal guardian. **Please have your parent/guardian complete Section B below.**

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 have submitted the Special Consent for Athletes with Down syndrome, available from the Special Olympics program in my state, or I have had a full radiological examination which established the absence of Atlanto-axial Instability. I am aware that if I choose not to complete the Special Consent for Athletes with Down syndrome form which established the absence of Atlanto-axial Instability, I must have the radiological examination before I can participate in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in aquatics, 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, Web site 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 be used for these purposes and activities.

If, during my participation in Special Olympics, 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 of the consent that I am signing. I understand that by signing this paper, I am saying that I agree to the provisions of this consent.

\_\_\_\_\_  
**Signature of Adult Athlete (required)**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witnessing Adult (required)

\_\_\_\_\_  
Date

## section b: consent to be completed by parent or guardian of athlete

I am the parent/guardian of, \_\_\_\_\_, 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 the best of my knowledge and belief, the athlete is physically and mentally able to participate in Special Olympics activities. 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 two physicians and myself have completed the official Special Consent for Athletes with Down syndrome, available from the Special Olympics program in my state, or the athlete has 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 Consent for Athletes with Down syndrome form which established the absence of Atlanto-Instability, the athlete must have the radiological examination before he/she can participate in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in aquatics, high jump, alpine skiing and 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 those 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 personally 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, 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 consent, and have explained these provisions to the athlete. Through my signature on this consent form, I am agreeing to the above provisions on my own behalf and on the behalf of the athlete named above.

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

**Signature of Parent/Caregiver (required):** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_



**Special Olympics**  
Minnesota



Special Olympics, Inc. offers non-invasive health care services to athletes at local, state, national and World Games venues through the Healthy Athletes program. These services have included individual screening assessments of health status and health care needs, provision of health education, routine preventive services (e.g. protective mouth guards), educational services, and, in the case of vision and hearing deficits, provision of needed eyewear (glasses, swim goggles, protective eyewear) and hearing aids. Athletes are informed as to their health status and advised as to the need for follow-up care. In addition, information collected at the time services are provided has been invaluable for developing policies, securing resources and implementing programs to better meet the health needs of athletes.

Such health services will be made available to Special Olympics athletes where offered through Healthy Athletes venues. Services may be offered in the following areas: vision; oral health; hearing; physical therapy; and a variety of health promotion areas (height, weight, sun protection, etc.). These services will be free of charge and are available to all Special Olympics athletes whether they are competing at the specific Games event or not. The services will be delivered by qualified health professionals who, in addition, have received Special Olympics-provided training. Many of the volunteer health professionals have previous experience in serving Special Olympics athletes and other special needs patients.

**Authorization for Minors:** I authorize the participation of \_\_\_\_\_ (athlete's full name) in the Healthy Athletes screening venues. I understand that participation in the Healthy Athletes venues is voluntary and that authorization can be withdrawn at any time without penalty and that participation in Healthy Athletes is not a requirement for participating in other Special Olympics activities. I understand that the provision of these health services is not intended as a substitute or alternative to regular care that has been received in the past or that may be recommended in the future. I understand that information that is gathered as part of the screening process may be used in group form (anonymously) to assess and communicate the overall health needs of athletes and to develop programs to address those needs.

\_\_\_\_\_  
Athlete's Printed Name

\_\_\_\_\_  
Birthdate

\_\_\_\_\_  
Special Olympics Minnesota Delegation

\_\_\_\_\_  
Parent or Guardian Signature (for athletes 17 years old and under)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Athlete Signature (for athletes 18 years old or older)

\_\_\_\_\_  
Date

**NOTE: This authorization shall remain effective unless the consenting party requests termination or the scope of the Healthy Athletes program changes materially.**