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	
☐	☐	*Heart disease / heart defect / high blood pressure
☐	☐	*Chest pain
☐	☐	*Seizures / epilepsy/fainting spells
☐	☐	*Diabetes
☐	☐	*Concussion or serious head injury
☐	☐	*Major surgery or serious illness
☐	☐	*Blindness / visual problem
☐	☐	*Asthma
☐	☐	Heat stroke / exhaustion
☐	☐	Contact lenses / glasses
☐	☐	Hearing loss / hearing aid
☐	☐	Bone or joint problem

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

NOTE: If the athlete has Down syndrome, requires 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	
☐	☐	Vision
☐	☐	Hearing
☐	☐	Oral cavity
☐	☐	Neck
☐	☐	Extremities
☐	☐	Cardiovascular system
☐	☐	Respiratory system
☐	☐	Gastrointestinal system
☐	☐	Genitourinary system
☐	☐	Skin
☐	☐	Cranial nerves
☐	☐	Coordination
☐	☐	Reflexes

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:** (   ) ____________