




## **Special Olympics**

**Alaska**

*Anchorage Community*

**Be a fan..**

### **MEMO**

To: Heath Care Professionals  
From: Donna Davidson, Anchorage Community Director   
Date: July 13, 2010  
Re: Eligibility Guidelines for Participation

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Eligibility Guidelines for participation in Special Olympics Alaska per Special Olympics Inc. general rule.

By signing off on the application for participation in Special Olympics Alaska (medical form) you are saying the athlete meets the following requirements:

1. **Age Requirements.** Persons are eligible for Special Olympics, provided that they are 8 years of age or older.
2. **Identified as having intellectual disabilities.** A person is considered to have intellectual disabilities if:
  - a. An agency or professional has identified the person as having an intellectual disability; or
  - b. The person has a cognitive delay as determined by standard measures, such as IQ testing or other measures that are generally accepted within the professional community; or
  - c. The person has a closely related development disability, i.e. functional limitations in both general learning and adaptive skills. Persons with functional limitations based solely on physical, behavioral, emotional, or specific learning or sensory disabilities are not eligible.

If there are any questions regarding these stated guidelines, please feel free to contact the local community program.

*Special Olympics Alaska Anchorage Community* 222-6853  
*anchorage@specialolympicsalaska.org*

# APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS ALASKA

## DEMOGRAPHICS

Area: \_\_\_\_\_

Athlete's Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (if US Citizen)  Male  Female Date of Birth (month/day/year) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

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

Athlete's Address \_\_\_\_\_ Athlete Home Phone # \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Parent/Guardian's Name \_\_\_\_\_ Parent Primary Phone # \_\_\_\_\_  
 Parent/Guardian's Address (if different than athlete) \_\_\_\_\_ Parent Secondary Phone # \_\_\_\_\_

Emergency Contact (if other than parent/guardian) \_\_\_\_\_ Primary Phone # \_\_\_\_\_  
 Health/Accident Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

## HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER

<table border="0"> <tr><td>Yes</td><td>No</td><td></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>*Chest pain</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>*Diabetes</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>*Major surgery or serious illness</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>*Blindness / visual problem</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>Hearing loss / hearing aid</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Bone or joint problem</td></tr> </table> <p>Date of most recent tetanus immunization _____/_____/_____</p> <p>(*) Requires physical examination</p> <p><b>Medications:</b>          Please print medication name, amount, date prescribed and number of times per day medication is given.</p>	Yes	No		<input type="checkbox"/>	<input type="checkbox"/>	*Heart disease / heart defect / high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	*Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	*Seizures / epilepsy/fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	*Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	*Concussion or serious head injury	<input type="checkbox"/>	<input type="checkbox"/>	*Major surgery or serious illness	<input type="checkbox"/>	<input type="checkbox"/>	Heat stroke / exhaustion	<input type="checkbox"/>	<input type="checkbox"/>	*Blindness / visual problem	<input type="checkbox"/>	<input type="checkbox"/>	Contact lenses / glasses	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss / hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	Bone or joint problem	<table border="0"> <tr><td>Yes</td><td>No</td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Allergy:</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Medicines:</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>Insect stings/bites:</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>*Asthma</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Tobacco use</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Easy bleeding</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Emotional / psychiatric / behavioral</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>Immunizations up to date</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Other (for additional space, use back of form): _____</td></tr> </table>	Yes	No		<input type="checkbox"/>	<input type="checkbox"/>	Allergy:	<input type="checkbox"/>	<input type="checkbox"/>	Medicines:	<input type="checkbox"/>	<input type="checkbox"/>	Food:	<input type="checkbox"/>	<input type="checkbox"/>	Insect stings/bites:	<input type="checkbox"/>	<input type="checkbox"/>	Special diet	<input type="checkbox"/>	<input type="checkbox"/>	*Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco use	<input type="checkbox"/>	<input type="checkbox"/>	Easy bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Emotional / psychiatric / behavioral	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell trait or disease	<input type="checkbox"/>	<input type="checkbox"/>	Immunizations up to date	<input type="checkbox"/>	<input type="checkbox"/>	Other (for additional space, use back of form): _____
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Medication Name	Dosage	Date Prescribed.	Times per day	Medication Name	Dosage	Date Prescribed.	Times per day

Signature of parent/caregiver/adult athlete: \_\_\_\_\_ date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

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