

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>	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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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

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).

<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Has an x-ray evaluation for atlanto-axial instability been done?</p> <p><input type="checkbox"/> <input type="checkbox"/> If yes, was it positive for atlanto-axial instability? (positive indicates that the atlanto-dens interval is 5mm or more)</p>	
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PHYSICAL EXAMINATION

Blood pressure: _____/_____/_____ Weight: _____ Height: _____

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