Last Name:	Preferred Name:		
Date of Birth (dd/mm/yyyy):	Female	Male	
Race/Ethnicity (Optional):			
Language (s) Spoken in \$ W K O HIMMH	(Doptional):		
Street Address :		City:	
State/Province :	Country:	•	Postal Code:
Phone:	E-mail:		
Phone: Sports/Activities:	E-mail:		
	E-mail:		
	I .	her own behalf	? Yes No
Sports/Activities:	sent to medical treatment on his or		
Sports/Activities:  Does the athlete have the capacity to cons	sent to medical treatment on his or		
Sports/Activities:  Does the athlete have the capacity to cons  PARENT / GUARDIAN INFORMATION (re	sent to medical treatment on his or		
Sports/Activities:  Does the athlete have the capacity to cons	sent to medical treatment on his or		
Sports/Activities:  Does the athlete have the capacity to constant of the part	sent to medical treatment on his or		

### ATHLETE RELEASE FORM



I agree to the following:

- 1. Ability to Participate. I am physically able to take part in Special Olympics activities.
- 2. Likeness Release. I give permission to Special Olympics, Inc., Special Olympics games organizing committees, and Special 2 O\PSLFV DFFUHGLWHG 3 URJUDPV FROOHFWLYHO\ 3 6 SHFLDO 2 1001/08,SwLoFdV, 'andWR X\ biographical information to promote Special Olympics and raise funds for Special Olympics.
- 3. Risk of Concussion and Other Injury. I know there is a risk of injury. I understand the risk of continuing to play sports with or after a concussion or other injury. I may have to get medical care if I have a suspected concussion or other injury. I also may have to wait 7 days or more and get permission from a doctor before I start playing sports again.
- 4. Emergency Care. If I am unable, or my guardian is unavailable, to consent or make medical decisions in an emergency, I authorize Special Olympics to seek medical care on my behalf, unless I mark one of these boxes:

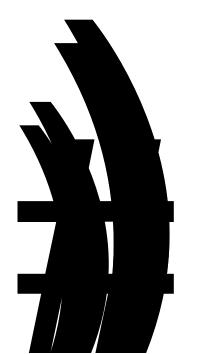
I have a religious or other objection to receiving medical treatment. (Not common.)

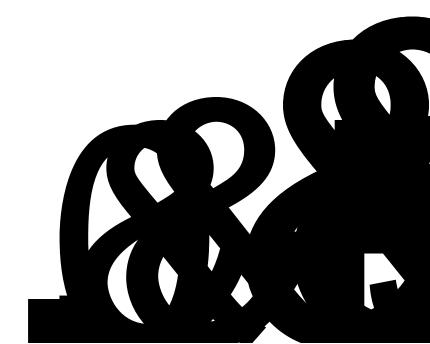
I do not consent to blood transfusions. (Not common.)

(If either box is marked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)

5. Overnight Stay. ) RU VRPH HYHQWV , PD\ VWD\ LQ D KRWHO RUbð[RWHO RUbð[R¶ðbU 0°ð and barnight Stay.

,Q FRQVLGHUDWLRQ RI EHLQJ DOORZHG WR SDUWLFLSDWH LQ DQ\ ZD\ LQ 6SHFLDO 20\PSLFV VS 'u´





# Athlete Medical Form ±HEALTH HISTORY

(To be completed by the athlete or parent/guardian/caregiver and brought to exam)



ASSOCIATED CONDITIONS - Does the athlete have	(check any that apply):	
Autism	Down Syndrome	Fragile X Syndrome
Cerebral Palsy	Fetal Alcohol Syndrome	
Other Syndrome, please specify:		

ALLERGIES & DIETARY RESTRICTIONS	ASSIST, 9 ( DEVICES- Does the athlete use (check any that apply):				
No Known Allergies	Brace	Colostomy	Communication Device		
Latex	C-PAP Machine	Crutches or Walker	Dentures		
Medications:	Glasses or Contacts	G-Tube or J-Tube	Hearing Aid		
Insect Bites or Stings:	Implanted Device	Inhaler	Pacemaker		
Food:	Removable Prosthetics	Splint	Wheel Chair		

List any special dietary needs:

#### SPORTS PARTICIPATION

List all Special Olympics sports the athlete wishes to play:

+DV D GRFWRU HYHU OLPLWHG WKH DWKOHWH¶V SDUWLFLSDWLRQ LQ VSRUWV" If yes, please describe: No Yes

### SURGERIES, INFECTIONS, VACCINES

List all past surgeries:

Does the athlete currently have any chronic or acute infection? No If yes, please describe:

# Athlete Medical Form ±HEALTH HISTORY

(To be completed by the athlete or parent/guardian/caregiver and brought to Exam

HAS THE ATHLETE EVER BEEN DIAGNOSED WITH OR EXPERIENCED ANY OF THE FOLLOWING CONDITIONS



# Athlete Medical Form ±MEDICAL REFERRAL FORM

(To be completed by a Licensed Medical Professional only if referral is needed



This page only needs to be completed and signed if the physician on page three does not clear the athlete and indicates further evaluation is required.

Athlete should bring the previously completed pages to the appointment with the specialist.

([DPLQHU¶<u>V 1DPH</u> H