Last Name:	Preferred Name:	
Date of Birth (dd/mm/yyyy) :	Female Male	
Race/Ethnicity (Optional):		
Language (s) Spoken in $WKOHWH¶V Home (Optional):		
Street Address :	City:	
State/Province :	Country:	Postal Code:
Phone :	E-mail:	
Sports/Activities:		
Does the athlete have the capacity to consent to medical treatment on his or her own behalf?	Yes	No
PARENT / GUARDIAN INFORMATION (required if minor or otherwise has a legal guardian)		

Name:

Street Address:	City:	
State/Province :	Country:	Postal Code:

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 2O\PSLFV DFFUHGLWHG 3URJUDPV FROOHFWLYHO\ ³6SHFLDO 2O\PSLFV´ Code, Words, and WR XV 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

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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
Cerebral Palsy
Down Syndrome
Fetal Alcohol Syndrome
Fragile X Syndrome

Other Syndrome, please specify:____

ALLERGIES & DIETARY RESTRICTIONS

No Known Allergies
Latex
Medications:____________________________________
Insect Bites or Stings:__________________________
Food:____

ASSIST , 9 (DEVICES- Does the athlete use (check any that apply):

Brace
C-PAP Machine
Glasses or Contacts
Implanted Device
Removable Prosthetics
Colostomy
Crutches or Walker
G-Tube or J-Tube
Inhaler
Splint
Communication Device
Dentures
Hearing Aid
Pacemaker
Wheel Chair

List any special dietary needs:

SPORTS PARTICIPATION

List all Special Olympics sports the athlete wishes to play:

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No Yes If yes, please describe:

SURGERIES, INFECTIONS, VACCINES

List all past surgeries:

Does the athlete currently have any chronic or acute infection?
No Yes 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.

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