APPLICATION FOR PARTICPATION

Special Olympics New Hampshire

Local Program Name:_____

Are you a new athlete to SO New Hampshire or Re-Registering? ☐ New Athlete ☐ Re-Registering ☐ Update

ATHLETE INFORMATION		
First Name:	**Middle Name:**	
Last Name:	**Preferred Name:**	
Date of Birth (mm/dd/yyyy):	☐ Female ☐ Male ☐ Other Gender Identity	
Race/Ethnicity: ☐ American Indian/Alaskan Native ☐ Asian American ☐ Prefer not to answer ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ More than one race ☐ White or Caucasian ☐ Hispanic or Latinx		
Language(s) Spoken in Athlete's Home (Optional): Check all that apply ☐ English ☐ Spanish ☐ Other (please list):		
Home Address:		
City:	**State:**	**Zip Code:**
Phone: ☐Cell Phone ☐ Work Phone ☐ Home Phone		
E-mail:		
T-Shirt Size (XS - 5XL): *Please select youth or adult and write in size.* ☐Youth ☐Adult		
Athlete Employer (if applicable):		
Is the athlete their own guardian? ☐Yes ☐ No		
PARENT / GUARDIAN INFORMATION (required if minor or otherwise has a legal guardian)		
First Name:	**Last Name:**	
Relationship:		
☐ **Same Contact Info as Athlete**		
Home Address:		
City:	**State:**	**Zip Code:**
Phone: ☐Cell Phone ☐ Work Phone ☐ Home Phone		
E-mail:		
EMERGENCY CONTACT INFORMATION		
☐ **Same as Parent/Guardian**	**Relationship:**	
First Name:	**Last Name:**	
Phone: ☐Cell Phone ☐ Work Phone ☐ Home Phone		
E-mail		
PHYSICIAN & INSURANCE INFORMATION		
Physician Name:		
Physician Phone:		
Insurance Company:	**Insurance Policy Number:**	
Insurance Group Number:		

ATHLETE RELEASE FORM

Special Olympics New Hampshire

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 Olympics accredited Programs (collectively "Special Olympics") to use my likeness, photo, video, name, voice, words, and 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 (visit www.sonh.org to access the form).
5. **Overnight Stay.** For some events, I may stay in a hotel or someone's home. If I have questions, I will ask.
6. **Health Programs.** If I take part in a health program, I consent to health activities, screenings, and treatment. This should not replace regular health care. I can say no to treatment or anything else at any time.
7. **Personal Information.** I understand that Special Olympics will be collecting my personal information as part of my participation, including my name, image, address, telephone number, health information, and other personally identifying and health related information I provide to Special Olympics ("personal information").
   - I agree and consent to Special Olympics:
     - using my personal information in order to: make sure I am eligible and can participate safely; run trainings and events; share competition results (including on the Web and in news media); provide health treatment if I participate in a health program; analyze data for the purposes of improving programming and identifying and responding to the needs of Special Olympics participants; perform computer operations, quality assurance, testing, and other related activities; and provide event-related services.
     - using my contact information for communicating with me about Special Olympics.
     - sharing my personal information confidentially with (i) researchers such as universities and public health agencies that are studying intellectual disabilities and the impact of Special Olympics activities, (ii) medical professionals in an emergency, and (iii) government authorities for the purpose of assisting me with any visas required for international travel to Special Olympics events and for any other purpose necessary to protect public safety, respond to government requests, and report information as required by law.
   - I have the right to ask to see my personal information or to be informed about the personal information that is processed about me. I have the right to ask to correct and delete my personal information, and to restrict the processing of my personal information if it is inconsistent with this consent.
   - *Privacy Policy*. Personal information may be used and shared consistent with this form and as further explained in the Special Olympics privacy policy at https://www.sonh.org/privacy-policy/.

Athlete Name:	
ATHLETE SIGNATURE (required for adult athlete with capacity to sign legal documents)	
I have read and understand this form. If I have questions, I will ask. By signing, I agree to this form.	
Athlete Signature:	**Date:**
PARENT/GUARDIAN SIGNATURE (required for athlete who is a minor or lacks capacity to sign legal documents)	
I am a parent or guardian of the athlete. I have read and understand this form and have explained the contents to the athlete as appropriate. By signing, I agree to this form on my own behalf and on behalf of the athlete.	
Parent/Guardian Signature:	**Date:**
Printed Name:	**Relationship:**

HEALTH HISTORY

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

Special Olympics

Athlete First & Last Name:_____ **Preferred Name:**_____

Athlete Date of Birth (mm/dd/yyyy):_____ ☐ Female ☐ Male ☐ Other Gender Identity

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

☐ No Known Allergies

☐ Latex

☐ Medications:_____

☐ Insect Bites or Stings:_____

☐ Food:

ASSISTIVE DEVICES - Does the athlete use *(check any that apply)*:

☐ Brace ☐ Colostomy ☐ Communication Device

☐ C-PAP Machine ☐ Crutches or Walker ☐ Dentures

☐ Glasses or Contacts ☐ G-Tube or J-Tube ☐ Hearing Aid

☐ Implanted Device ☐ Inhaler ☐ Pacemaker

☐ Removable Prosthetics ☐ Splint ☐ Wheel Chair

List any special dietary needs:

SPORTS PARTICIPATION

List all Special Olympics sports the athlete wishes to play:

Has a doctor ever limited the athlete's participation in sports?

☐ 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:*

Has the athlete ever had an abnormal Electrocardiogram (EKG) or Echocardiogram (Echo)? *If yes, describe date and results*

☐ Yes, had abnormal EKG

☐ Yes, had abnormal Echo

Has the athlete had a Tetanus vaccine in the past 7 years? ☐ No ☐ Yes

EPILEPSY AND/OR SEIZURE HISTORY

Epilepsy or any type of seizure disorder ☐ No ☐ Yes

*If yes, list seizure type:*_____

If yes, had seizure during the past year? ☐ No ☐ Yes

MENTAL HEALTH

Self-injurious behavior during the past year ☐ No ☐ Yes

Aggressive behavior during the past year ☐ No ☐ Yes

Depression *(diagnosed)* ☐ No ☐ Yes

Anxiety *(diagnosed)* ☐ No ☐ Yes

Describe any additional mental health concerns:

FAMILY HISTORY

Has any relative died of a heart problem before age 50? ☐ No ☐ Yes

Has any family member or relative died while exercising? ☐ No ☐ Yes

List all medical conditions that run in the athlete's family:

HEALTH HISTORY

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

Athlete's First and Last Name:_____

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

Loss of Consciousness	☐ No	☐ Yes	High Blood Pressure	☐ No	☐ Yes	Stroke/TIA	☐ No	☐ Yes
Dizziness during or after exercise	☐ No	☐ Yes	High Cholesterol	☐ No	☐ Yes	Concussions	☐ No	☐ Yes
Headache during or after exercise	☐ No	☐ Yes	Vision Impairment	☐ No	☐ Yes	Asthma	☐ No	☐ Yes
Chest pain during or after exercise	☐ No	☐ Yes	Hearing Impairment	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes
Shortness of breath during or after exercise	☐ No	☐ Yes	Enlarged Spleen	☐ No	☐ Yes	Hepatitis	☐ No	☐ Yes
Irregular, racing or skipped heart beats	☐ No	☐ Yes	Single Kidney	☐ No	☐ Yes	Urinary Discomfort	☐ No	☐ Yes
Congenital Heart Defect	☐ No	☐ Yes	Osteoporosis	☐ No	☐ Yes	Spina Bifida	☐ No	☐ Yes
Heart Attack	☐ No	☐ Yes	Osteopenia	☐ No	☐ Yes	Arthritis	☐ No	☐ Yes
Cardiomyopathy	☐ No	☐ Yes	Sickle Cell Disease	☐ No	☐ Yes	Heat Illness	☐ No	☐ Yes
Heart Valve Disease	☐ No	☐ Yes	Sickle Cell Trait	☐ No	☐ Yes	Broken Bones	☐ No	☐ Yes
Heart Murmur	☐ No	☐ Yes	Easy Bleeding	☐ No	☐ Yes	Dislocated Joints	☐ No	☐ Yes
Endocarditis	☐ No	☐ Yes	**If female athlete, list date of last menstrual period:**_____					

Describe any past broken bones or dislocated joints *(if yes is checked for either of those fields above)*:

List any other ongoing or past medical conditions:

Neurological Symptoms for Spinal Cord Compression and Atlanto-axial Instability

Difficulty controlling bowels or bladder	☐ No	☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No	☐ Yes
Numbness or tingling in legs, arms, hands or feet	☐ No	☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No	☐ Yes
Weakness in legs, arms, hands or feet	☐ No	☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No	☐ Yes
Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet	☐ No	☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No	☐ Yes
Head Tilt	☐ No	☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No	☐ Yes
Spasticity	☐ No	☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No	☐ Yes
Paralysis	☐ No	☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No	☐ Yes

PLEASE LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW

(includes inhalers, birth control or hormone therapy)

Medication, Vitamin or Supplement Name	*Dosage*	*Times per Day*	*Medication, Vitamin or Supplement Name*	*Dosage*	*Times per Day*	*Medication, Vitamin or Supplement Name*	*Dosage*	*Times per Day*

Is the athlete able to administer his or her own medications? ☐ No ☐ Yes

Name of Person Completing this Form	**Relationship to Athlete**	**Phone**	**Email**

PHYSICAL EXAM

(To be completed by Licensed Medical Professional qualified to conduct exams & prescribe medications)

Athlete's First and Last Name:_____ **Date of Birth**_____

MEDICAL PHYSICAL INFORMATION

(To be completed by a Licensed Medical Professional qualified to conduct physical exams and prescribe medications)

Height	Weight	BMI *(optional)*	Temperature	Pulse	O_2Sat	Blood Pressure (in mmHg)		Vision
cm	kg	BMI	C			BP Right:	BP Left:	Right Vision 20/40 or bette ☐ No ☐ Yes ☐ N/A
in	lbs	Body Fat %	F					Left Vision 20/40 or bette ☐ No ☐ Yes ☐ N/A

Right Hearing (Finger Rub)	☐ Responds	☐ No Response	☐ Can't Evaluate		Bowel Sounds	☐ Yes	☐ No
Left Hearing (Finger Rub)	☐ Responds	☐ No Response	☐ Can't Evaluate		Hepatomegaly	☐ No	☐ Yes
Right Ear Canal	☐ Clear	☐ Cerumen	☐ Foreign Body		Splenomegaly	☐ No	☐ Yes
Left Ear Canal	☐ Clear	☐ Cerumen	☐ Foreign Body		Abdominal Tenderness	☐ No	☐ RUQ ☐ RLQ ☐ LUQ ☐ LLQ
Right Tympanic Membrane	☐ Clear	☐ Perforation	☐ Infection	☐ NA	Kidney Tenderness	☐ No	☐ Right ☐ Left
Left Tympanic Membrane	☐ Clear	☐ Perforation	☐ Infection	☐ NA	Right upper extremity reflex	☐ Normal	☐ Diminished ☐ Hyperreflexia
Oral Hygiene	☐ Good	☐ Fair	☐ Poor		Left upper extremity reflex	☐ Normal	☐ Diminished ☐ Hyperreflexia
Thyroid Enlargement	☐ No	☐ Yes			Right lower extremity reflex	☐ Normal	☐ Diminished ☐ Hyperreflexia
Lymph Node Enlargement	☐ No	☐ Yes			Left lower extremity reflex	☐ Normal	☐ Diminished ☐ Hyperreflexia
Heart Murmur (supine)	☐ No	☐ 1/6 or 2/6	☐ 3/6 or greater		Abnormal Gait	☐ No	☐ Yes, describe below
Heart Murmur (upright)	☐ No	☐ 1/6 or 2/6	☐ 3/6 or greater		Spasticity	☐ No	☐ Yes, describe below
Heart Rhythm	☐ Regular	☐ Irregular			Tremor	☐ No	☐ Yes, describe below
Lungs	☐ Clear	☐ Not clear			Neck & Back Mobility	☐ Full	☐ Not full, describe below
Right Leg Edema	☐ No	☐ 1+ ☐ 2+	☐ 3+ ☐ 4+		Upper Extremity Mobility	☐ Full	☐ Not full, describe below
Left Leg Edema	☐ No	☐ 1+ ☐ 2+	☐ 3+ ☐ 4+		Lower Extremity Mobility	☐ Full	☐ Not full, describe below
Radial Pulse Symmetry	☐ Yes	☐ R>L	☐ L>R		Upper Extremity Strength	☐ Full	☐ Not full, describe below
Cyanosis	☐ No	☐ Yes, describe			Lower Extremity Strength	☐ Full	☐ Not full, describe below
Clubbing	☐ No	☐ Yes, describe			Loss of Sensitivity	☐ No	☐ Yes, describe below

SPINAL CORD COMPRESSION & ATLANTO-AXIAL INSTABILITY (AAI) *(Select one)*

☐ **Athlete shows NO EVIDENCE of neurological symptoms or physical findings associated with spinal cord compression or atlanto-axial instability.**

OR

☐ **Athlete has neurological symptoms or physical findings that could be associated with spinal cord compression or atlanto-axial instability and must receive an additional neurological evaluation to rule out additional risk of spinal cord injury prior to clearance for sports participation.**

ATHLETE CLEARANCE TO PARTICIPATE (*TO BE COMPLETED BY EXAMINER ONLY*)

Licensed Medical Examiners: It is recommended that the examiner review items on the medical history with the athlete or their guardian, prior to performing the physical exam. If an athlete needs further medical evaluation please make a referral below and second physician for referral should complete page 4.

☐ **This athlete is ABLE to participate in Special Olympics sports without restrictions.**

☐ **This athlete is ABLE to participate in Special Olympics sports WITH restrictions. Describe →** _____

☐ **This athlete MAY NOT participate in Special Olympics sports at this time & MUST be further evaluated by a physician for the following concerns:**

- ☐ Concerning Cardiac Exam
- ☐ Concerning Neurological Exam
- ☐ Other, please describe:
- ☐ Acute Infection
- ☐ Stage II Hypertension or Greater
- ☐ O_2 Saturation Less than 90% on Room Air
- ☐ Hepatomegaly or Splenomegaly

Additional Licensed Examiner's Notes and Recommended (but not required) Follow-up:

- ☐ Follow up with a cardiologist
- ☐ Follow up with a vision specialist
- ☐ Follow up with a podiatrist
- ☐ Follow up with a neurologist
- ☐ Follow up with a hearing specialist
- ☐ Follow up with a physical therapist
- ☐ Follow up with a primary care physician
- ☐ Follow up with a dentist or dental hygienist
- ☐ Follow up with a nutritionist
- ☐ Other/Exam Notes:

	Name:
	E-mail:
Signature of Licensed Medical Examiner Exam Date	Phone: License #: