

Athlete Enrollment/Medical Release Form

(The form must be completely filled out or it will be returned.)

Check One: Renewal New Updated

Submission Date: _____

A: Athlete's Name: _____ **Home Phone:** (____) _____

Sex: _____ **Age:** _____ **Date of Birth:** ____/____/____

Street Address: _____

City: _____ **State:** _____ **ZIP:** _____

Solely to help us comply with government record keeping, reporting and other legal requirements, please check what applies:

White Black Hispanic American Indian/Alaskan Native Asian Pacific Islander Other _____

B: Head of Delegation: Jim Domer **Delegation Code:** LEW10

Home Phone: (____) 972-571-8092 **Work Phone:** (____) Same

Street Address: 2080 Stillwater Place

City: Lewisville **State:** Texas **ZIP:** 75067

C: Parent/Guardian Name: _____ **E-mail:** _____

Home Phone: (____) _____ **Work Phone:** (____) _____

Street Address: _____

City: _____ **State:** _____ **ZIP:** _____

D: Person to Notify in Case of an Emergency (Check if it is the same as above.)

Name: _____ **Relationship to Athlete:** _____

Home Phone: (____) _____ **Work Phone:** (____) _____

Street Address: _____

City: _____ **State:** _____ **ZIP:** _____

E: Name of Person Completing this Form: _____

Physical Examination	Normal/Abnormal	Normal/Abnormal	Normal/Abnormal
Athlete's height: _____	<input type="checkbox"/> <input type="checkbox"/> Vision	<input type="checkbox"/> <input type="checkbox"/> Cardiovascular system	<input type="checkbox"/> <input type="checkbox"/> Cranial nerves
Weight: _____	<input type="checkbox"/> <input type="checkbox"/> Hearing	<input type="checkbox"/> <input type="checkbox"/> Respiratory system	<input type="checkbox"/> <input type="checkbox"/> Coordination
Blood pressure: ____/____	<input type="checkbox"/> <input type="checkbox"/> Oral cavity	<input type="checkbox"/> <input type="checkbox"/> Gastrointestinal system	<input type="checkbox"/> <input type="checkbox"/> Reflexes
	<input type="checkbox"/> <input type="checkbox"/> Neck	<input type="checkbox"/> <input type="checkbox"/> Genitourinary system	<input type="checkbox"/> <input type="checkbox"/> Extremities
	<input type="checkbox"/> <input type="checkbox"/> Skin		

- | | | | |
|---|------------------------------|-----------------------------|--------------------------------------|
| 1. Heart disease/heart defect/high blood pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| 2. Chest pain or fainting spells | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| 3. Seizures/Epilepsy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| 4. Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| 5. Down syndrome | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Have cervical spine (neck bone) x-rays been done? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Atlantoaxial Instability | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> New problem |
| 6. Blindness/visual problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> New problem |
| 7. Absence of one kidney or testicle | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> New problem |
| 8. Concussion or serious head injury | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> New problem |
| 9. Major surgery or serious illness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> New problem |
| 10. Heat exhaustion/stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> New problem |
| 11. Other problems that would interfere with sports participation | | | |
| 12. Impaired motor ability | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> New problem |
| 13. Uses a wheel chair | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> New problem |
| 14. Allergic to the following | | | |
| Medicines _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> New problem |
| Foods _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> New problem |
| Insect sting/bite _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> New problem |
| 15. Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> New problem |
| 16. Tendency to bleed easily | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> New problem |
| 17. Emotional problems/psychiatric disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> New problem |
| 18. Serious bone or joint disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> New problem |
| 19. Sickle Cell trait or disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> New problem |
| 20. Contact lenses/eyeglasses | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> New problem |
| 21. Hearing aid/hearing loss | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> New problem |
| 22. Immunizations are up to date | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> New problem |
| 23. Date of last tetanus ____/____/____ | | | |

Please Note

- * An up-to-date health history and a physical examination performed by a licensed physician is required upon entry into the program.
- * A physical examination is required every 3 years for items 1-5.
- * A physical examination is required for all athletes with a "new problem" response to items 6-10.
- * Athletes must submit a Medical Release Form every 3 years whether or not an examination is needed.

Current Prescription Medication

- * First Medication: _____
Amount: _____
Time: _____
Date Prescribed: ____/____/____
- * Second Medication: _____
Amount: _____
Time: _____
Date Prescribed: ____/____/____
- * Third Medication: _____
Amount: _____
Time: _____
Date Prescribed: ____/____/____

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MEDICAL CERTIFICATION

Notice to Physicians: If the athlete has Down syndrome, Special Olympics Texas requires that the athlete have a full radiological examination establishing the absence of Atlantoaxial Instability before he/she may participate in sports or events which, by their nature, may result in hyperextension, radial flexion or direct pressure on the neck or upper spine. The sports and events for which such a radiological examination is required are: equestrian, gymnastics, diving, pentathlon, butterfly stroke, diving starts in aquatics, high jump, alpine skiing, soccer and warm-up exercises placing undue stress on head or neck.

Check Here: I have reviewed the above information on and examined the athlete named in the application, and certify there is not medical evidence available to me that would preclude the athlete's participation in Special Olympics Texas.

Restrictions: _____

Physician Name (print): _____

Physician assistant licensed by State Board of Physician Assistant Examiners or registered nurse recognized as an advanced practice nurse by the Board of Nurse Examiners.

Physician Signature: _____ Date: _____/_____/_____

Address: _____ City: _____ State: _____ ZIP: _____

Phone No: (_____) _____

Please provide name of athlete's insurance company: _____

Please provide medical insurance company's phone number: _____

It is understood and agreed that: If the examiner is provided free of charge, it is not intended to be a thorough or comprehensive examination. No physician-patient relationship is to arise out of the examination. The doctor, nurse or other person involved in the examination is under no obligation to provide a diagnosis, treatment, advice, consultation or any follow-up care whatsoever under any circumstances. The fact that any person is cleared or authorized to participate in any sport or other activity does not mean and is not to be interpreted as the opinion of the doctor or nurse that the person examined is healthy, in need of no care, or can participate in any sport or other activity without serious medical risks. Any claim against the doctor, nurse or other person involved in the examination will be submitted to binding arbitration pursuant to the rules and procedures of the American Arbitration Association. The person examined and any person who signs on his or her behalf promises to indemnify the doctor or nurse from any and all damages, claims, or losses, including injury or death that allegedly arise out of or are in any way related to the examination.

Participation: I hereby give my permission for the participant named above to participate in any Special Olympics activity or event of any kind. I understand that participation at local or area competition does not guarantee advancement to State, National or World Games. Athletes must be registered using this release form prior to any athlete training.

Medical: I represent and warrant to you that the athlete is physically and mentally able to participate in Special Olympics Texas.

Disclaimer: On behalf of the athlete and myself, I acknowledge that the athlete will be using facilities at his/her own risk and I, on my own behalf, hereby release the physicians, organizers, officers, directors, agents or employees of Special Olympics Texas from any claim for damage or suit by reason of any injury, illness, or damage whatsoever to person or property of myself or the athlete.

Hospitalization: If I am not personally present at the event in which the athlete is to compete so as to be consulted in case of emergency, you are authorized on my behalf and at my account to take such measure and arrange for such medical and hospital treatment as you may deem advisable for the health and well-being of the athlete.

Media: In permitting the athlete to participate, I am specifically granting permission to you to use the name, likeness, voice and words of the athlete in television, radio, films, newspapers, magazines, Web pages and other media, and in any form not heretofore described for the purpose of advertising or communicating the purposes and activities of Special Olympics Texas and in appealing for funds to support such activities.

Check One: Parent Guardian Athlete (if over the age of 18)

Parent/Guardian/Athlete Signature: _____

Print Name of Above: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Please list sports in which athlete will compete: _____