

APPLICATION FOR ATHLETE PARTICIPATION IN SPECIAL OLYMPICS IDAHO

Valid for three (3) years from physical exam date

NEW or RENEWAL (circle one)



Special Olympics

Idaho

Be a fan™

Instructions: Complete and sign pages 1 – 4 of this application. Include pages 5 and 6 if applicable.

Return to Special Olympics Idaho mail: 199 E 52nd St Garden City Id 83714, fax: 208.323.0486 email: idso@idso.org

If Athlete has had a physical exam within the last year, it may qualify as sufficient for page 2 of this application.

Please complete the **BEHAVIORAL CERTIFICATION** section on page 2 and include recent physical exam report with this application.

Team Name:		Ethnic background (optional) <input type="checkbox"/> Caucasian, <input type="checkbox"/> Hispanic, <input type="checkbox"/> Asian, <input type="checkbox"/> Native American, <input type="checkbox"/> African American, <input type="checkbox"/> Other	
Athlete's Social Security #	(if US Citizen)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (month/day/year)
Athlete's Name		_____ / _____ / _____	
Athlete's Address		Athlete Phone	@
City	State	Zip	Athlete Email
Does Athlete live at a care facility? <input type="checkbox"/> No <input type="checkbox"/> Yes		Facility Name	Facility Phone () -
Parent/Guardian's Name		Primary Phone	() -
Parent/Guardian's Address (if different than athlete)		Secondary Phone	() -
		Parent Email	@
Emergency Contact (if other than parent/guardian)		Emergency Phone	() -
Health/Accident Insurance Company		Policy #	

HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER or ADULT ATHLETE (*) Requires physical examination					
Yes	No	<i>If yes, please make notation next to condition</i>	Yes	No	<i>If yes, please make notation next to condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	*Heart disease / heart defect / high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Allergy:
<input type="checkbox"/>	<input type="checkbox"/>	*Chest pain			Medicines:
<input type="checkbox"/>	<input type="checkbox"/>	*Seizures / epilepsy / fainting spells			Food:
<input type="checkbox"/>	<input type="checkbox"/>	Wheelchair use			Insect stings/bites:
<input type="checkbox"/>	<input type="checkbox"/>	*Concussion or serious head injury	<input type="checkbox"/>	<input type="checkbox"/>	Special diet
<input type="checkbox"/>	<input type="checkbox"/>	*Major surgery or serious illness	<input type="checkbox"/>	<input type="checkbox"/>	*Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Heat stroke / exhaustion	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco use
<input type="checkbox"/>	<input type="checkbox"/>	*Blindness / visual problem	<input type="checkbox"/>	<input type="checkbox"/>	Easy bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Contact lenses / glasses	<input type="checkbox"/>	<input type="checkbox"/>	Emotional / psychiatric / behavioral
<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss / hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell trait or disease
<input type="checkbox"/>	<input type="checkbox"/>	Bone or joint problem	<input type="checkbox"/>	<input type="checkbox"/>	Immunizations up to date
Date of most recent tetanus immunization _____ / _____ / _____			<input type="checkbox"/>	<input type="checkbox"/>	Other for additional space use back of form

CIRCLE ONE

NEEDS ONE ON ONE SUPERVISION? YES NO REASON:

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
Sign here _____							
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).

Yes No

- Has an x-ray evaluation for atlanto-axial instability been done?
- If yes, was it positive for atlanto-axial instability? (positive indicates that the atlanto-dens interval is 5mm or more)

PHYSICAL EXAMINATION

Blood pressure: ____/____ Weight: ____ Height: ____ Heart Rate: ____/____

Normal/Abnormal			Normal/Abnormal			Normal/Abnormal		
<input type="checkbox"/>	<input type="checkbox"/>	Vision	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular system	<input type="checkbox"/>	<input type="checkbox"/>	Cranial nerves
<input type="checkbox"/>	<input type="checkbox"/>	Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory system	<input type="checkbox"/>	<input type="checkbox"/>	Coordination
<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			

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, who has been identified by an agency or a professional as having an intellectual disability or a closely related developmental disability, can participate in Special Olympics.

RESTRICTIONS:

BEHAVIORAL CERTIFICATION

In order to provide a safe environment for all Special Olympics Idaho athletes, volunteers and employees, it is the policy of special Olympics Idaho that persons with backgrounds of deviant sexual behavior or acts of violence will be excluded from all Special Olympics Idaho programs. Acts of violence which will mandate exclusion are those in which there is a substantial risk that physical harm will be inflicted by the individual upon another as evidenced by behavior which has caused such harm.

To the best of your knowledge, has this athlete at any time exhibited:

Violent Behavior	YES	NO
Sexually Deviant Behavior	YES	NO

If you marked "YES" to either of these questions, please complete the Athlete Profile attached. If you have any questions, please contact the Special Olympics Idaho Chapter Office at 1-800-915-6510.

EXAMINER'S SIGNATURE: _____ Date: ____/____/____

EXAMINER'S NAME (please print): _____

ADDRESS: _____ Phone: _____ e-mail: _____

FAMILY PHYSICIAN (if different than Examiner)

ADDRESS: _____ Phone: _____ e-mail: _____



OFFICIAL SPECIAL OLYMPICS RELEASE FORM

RELEASE TO BE COMPLETED BY ADULT ATHLETE

I, _____ am at least 18 years old and have submitted the attached application for participation in Special Olympics. I represent and warrant that, to the best of my knowledge and belief, I am physically and mentally able to participate in Special Olympic activities. I also represent that a licensed physician has reviewed the health information contained in my application and has certified, based on an independent medical examination, that there is no medical evidence that would preclude me from participating in Special Olympics. I understand that if I have Down syndrome, I cannot participate in sports or events that by their nature result in h hyper-extension, radical flexion or direct pressure on my neck or upper spine unless I have had a full radiological examination which establishes the absence of Atlanto-axial instability. I am aware that I must have this radiological examination before I can participate in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, and soccer.

Special Olympics has my permission, both during and anytime after, to use my likeness, name, voice, or words in either television, radio, film, newspapers, magazine, and other media, and in any form, for the purpose of advertising or communicating the purposes and activities of Special Olympics and/or applying for funds to support those purposes and activities.

If, during my participation in Special Olympics activities, I should need emergency medical treatment, and I am not able to give my consent or make my own arrangements for that treatment because of my injuries, I authorize Special Olympics to take whatever measures are necessary to protect my health and well-being, including if necessary, hospitalization.

I, the athlete named above, have read this paper and fully understand the provisions of the release that I am signing. I understand that by signing this paper, I am saying that I agree to the provisions of this Release.

Signature of Adult Athlete Date

I hereby certify that I have reviewed this Release with the athlete whose signature appears above. I am satisfied based on that review that the athlete understands this Release and has agreed to its terms.

Name (Print): _____

Relationship to athlete: _____
(family member, teacher, coach, etc.)

RELEASE TO BE COMPLETED BY PARENT OR GUARDIAN OF MINOR ATHLETE

I am the parent/guardian of _____, the minor athlete on whose behalf I have submitted the attached Application for Participation in Special Olympics. I hereby represent that the athlete has my permission to participate in Special Olympics activities.

I further represent and warrant that to the best of my knowledge and belief, the athlete is physically and mentally able to participate in Special Olympics. With my approval, a licensed physician has reviewed the health information set forth in the athlete’s Application and has certified based on an independent medical examination that there is no medical evidence which would preclude the athlete’s participation. I understand that if the athlete has Down Syndrome, the athlete cannot participate in sports or events which by their nature result in hyper-extension, radical flexion or direct pressure on the neck or upper spine, unless a full radiological examination establishes the absence of Atlanto-axial instability. I am aware that the sports and events for which this radiological examination is required are equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, and soccer.

In permitting the athlete to participate, I am specifically granting my permission, both during and anytime after to Special Olympics to use the athlete’s likeness, name, voice, or words in television, radio, film, newspapers, magazine, and other media and in any form for the purpose of advertising or communicating the purposes and activities of Special Olympics and/or applying for funds to support those purposes and activities.

If a medical emergency should arise during the athlete’s participation in any special Olympics activities, at a time when I am not personally present so as to be consulted regarding the athlete’s care, I hereby authorize Special Olympics, on my behalf, to take whatever measures are necessary to ensure that the athlete is provided with any emergency medical treatment including hospitalization which Special Olympics deems advisable in order to protect the athlete’s health and well-being.

I am the parent/guardian of the athlete named in this Application. I have read and fully understand the provisions of the above Release and have explained these provisions to the athlete. Through my signature on this Release form, I am agreeing to the above provision on my own behalf and on the behalf of the athlete named above.

I hereby give my permission for the athlete named above to participate in Special Olympics Games, recreation programs and physical activity programs.

Signature of Parent/Guardian Date

SPECIAL OLYMPICS IDAHO ATHLETE’S CODE OF CONDUCT

Special Olympics Idaho is committed to the highest ideals of sports and expects all athletes to honor sports and Special Olympics. All Special Olympics athletes and Unified Partners agree to the following code:

I. SPORTSMANSHIP

- A. I will practice good sportsmanship.
- B. I will act in ways that bring respect to me, my coaches, my team and Special Olympics Idaho.
- C. I will not use bad language.
- D. I will not swear or insult other persons, this includes gossiping about other athletes or anyone involved with Special Olympics.
- E. I will not fight with other athletes, coaches, volunteers, or staff.

II. TRAINING AND COMPETITION

- A. I will train regularly.
- B. I will learn and follow the rules of my sport.
- C. I will listen to my coaches and the officials and ask questions when I do not understand.
- D. I will always try my best during training, divisioning, and competitions.
- E. I will not “hold back” in preliminaries just to get into an easier final heat.

III. RESPONSIBILITY FOR MY ACTIONS

- A. I will not make inappropriate or unwanted physical, verbal or sexual advances on others.
- B. I will not drink alcohol, smoke or take illegal drugs while representing Special Olympics at training sessions, competition or during Games.
- C. I will not take drugs for the purpose of improving my performance.
- D. I will obey all laws and Special Olympics rules.

I understand that if I do not obey this Code of Conduct my Program or a Games Organizing Committee may not allow me to participate.

Dated this ____ day of _____, 20__.

Athlete Name Print

Athlete Signature

Parent/Guardian Name Print

Parent/Guardian Signature



Special Olympics Idaho - Safe Participation Plan

ATHLETE PROFILE

(Only to be completed if athlete has exhibited at any time Violent or Sexually Deviant behavior.)

Profile Date: _____

Athlete name: _____ SS# _____

Name of Person completing this profile: _____

Relationship to athlete: _____ Phone: _____

Parent / Guardian Name: _____ Phone: _____

Address: _____ City: _____

State: _____ Zip: _____ Does Athlete reside at this address? YES NO

Care Facility /Caregiver Name: _____ Phone: _____

Address: _____ State: _____ Zip: _____

How long has athlete resided at this address? Years _____ Months _____

Athlete Age: _____ Gender: M F Approx. Height: _____ Weight: _____

ATHLETE BEHAVIOR PROFILE

<u>Type of Behavior</u>	<u>Single or Multiple Incidents</u>	<u>Date of Last Incident</u>
Sexual Assault of Adult ----- M / F	Single / Multiple	_____
Sexual Exposure to Adult M / F	Single / Multiple	_____
Sexual Assault of child	Single / Multiple	_____
Sexual Exposure to child	Single / Multiple	_____
Sexual Harassment ----- M / F	Single / Multiple	_____
Physical Assault of adult ---- M / F	Single / Multiple	_____
Physical Assault of child	Single / Multiple	_____
Physical Self-abuse	Single / Multiple	_____
Verbal Assault	Single / Multiple	_____

Is the Athlete currently on legal probation? YES / NO If yes, describe the terms of probation.

Is athlete actively participating in a treatment program that specifically addresses the indicated behavior? YES / NO If YES, please describe treatment and frequency.

ATHLETE BEHAVIOR PROFILE

Cont'd.

Has a judge or other legal authority ordered this treatment? YES / NO

If YES, please describe any additional terms such as restriction of social activities.

Does athlete currently take medications for behavior modification? YES / NO

If YES, list Medications and Frequency: _____

Is there a specific stimulus / activity that has been identified as the trigger for the indicated behavior(s)?

YES / NO

Please list all behavior triggers and explain the circumstances of the most recent incident where athlete displayed the indicated behavior(s).

Describe athlete's understanding of his /her conduct – does athlete differentiate right from wrong behavior? Please explain. _____

Does the athlete currently display a positive, cooperative attitude under supervision? Please explain.

Please indicate athlete's communication skill level: check all that apply

- | | |
|---|---|
| <input type="checkbox"/> speech is clear, easily understood | <input type="checkbox"/> never speaks |
| <input type="checkbox"/> responds verbally when spoken to | <input type="checkbox"/> speech is not clear, difficult to understand |
| <input type="checkbox"/> does not usually speak | <input type="checkbox"/> uses sounds (not words) to communicate |
| <input type="checkbox"/> uses sign language only | <input type="checkbox"/> uses some words, some gestures |
| <input type="checkbox"/> usually maintains eye contact | <input type="checkbox"/> generally avoids eye contact |
| <input type="checkbox"/> other, explain _____ | |

Has individual participated in Special Olympics Idaho prior to today's date? YES / NO

If Yes, please list the team name(s), length of time athlete has participated, and in what sport(s).
