ATHLETE APPLICATION/MEDICAL RENEWAL INSTRUCTIONS

- **Athlete Applications (pages 1-2) expire every three years from the DATE OF EXAM**
- **New athletes are required to complete pages 1-3 of the Athlete Application**
- **Renewing athletes are required to complete pages 1-2 of the Athlete Application**
- **Athlete consent forms (page 3) expire when an athlete turns 18**

PAGE 1 Section A: Demographics REQUIRED FIELDS

- Athlete name, gender, address, phone number, date of birth
- Parent/guardian name and phone number *OR* emergency contact name and phone number

PAGE 1 Section B: Health History REQUIRED FIELDS

- ALL yes/no boxes must be checked
  - Criminal history box must be checked. If "yes" then the athlete will need a background check and disclosure forms will be sent from the state office.
  - Concussion box must be checked.
- Parent/guardian signature and date
  - If the athlete is their own guardian, they must sign and date this page.

PAGE 2 Section C: Physical Examination REQUIRED FIELDS

NOTE: This page must be completed by their doctor. The athlete's last physical exam can be used if they had one within the last year. The date of exam should always be used.

- ALL normal/abnormal boxes must be checked
- Specific questions regarding intellectual disability and Down Syndrome
  - If the doctor lists "none" or "learning disability" as the intellectual disability, this would not qualify the applicant to be eligible as an athlete with SOMN. They could still participate as a Unified Partner.
  - Atlantio-Axial Instability section only needs to be completed for Down Syndrome athletes
- Doctor's signature
- Date of exam
- Doctor's name, address and phone number

PAGE 3 Athlete Consent Form SECTION A OR SECTION B REQUIRED

- Section A is to be completed if the athlete is over 18 and is their own guardian. This needs to have the athlete's signature and date, and an adult witness signature and date.
- Section B is to be completed if the athlete is under 18 and/or is NOT their own guardian. This needs to have the guardian's signature & date.

PAGE 4 Healthy Athlete Consent Form THIS PAGE IS OPTIONAL

- If this page is completed, we need the athlete's name, signature and date filled out. Healthy Athletes are additional opportunities offered at various competitions throughout the year that require this additional consent.

Return completed forms via one of the options below:

- **EMAIL**: Scan the application pages for each athlete as one PDF file, attach to an email and send to athletepaperwork@somn.org
- Please do not email other file formats as this will delay processing
- **FAX** to 612-333-8782 and include a cover page with contact information
- **MAIL** to 900 2nd Ave S, Suite 300, Minneapolis, MN 55402 – if you choose to mail please make a copy first for your records

ATHLETE NAME: _____ DATE OF BIRTH: ____ / ____ / ____

APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS

Please print clearly and complete all sections in their entirety.
This application expires three (3) years from the date of exam.
People are eligible for Special Olympics provided they are age 8 or above and are considered to have an intellectual disability or closely related developmental disability, defined as functional limitations in both general learning and two or more adaptive skill areas: communication, leisure, self-direction, home living, community use, work, health and safety, academics, self-care and social skills.

State Office ONLY:
Delegation: _____
☐ Updated Form
☐ New Athlete
☐ in GMS
☐ not in GMS

Send completed forms to: SOMN, 900 2nd Ave S, Ste 300 Minneapolis, MN 55402
Email: athletepaperwork@somn.org Fax: 612.333.8782

SECTION A: DEMOGRAPHICS (Required)

Delegation: _____

Athlete Name: _____

Athlete Address: _____

City: _____ State: _____ Zip: _____

Parent/Guardian Name: _____

Parent/Guardian Address
(if different than athlete): _____

City: _____ State: _____ Zip: _____

Emergency Contact
(if other than Parent/Guardian): _____

Emergency Contact
Relationship to Athlete: _____

☐ Male ☐ Female Date of Birth: ____ / ____ / ____

Athlete Primary Phone: (_____) _____
(Circle one) home work cell

Athlete Email: _____

Parent Primary Phone: (_____) _____
(Circle one) home work cell

Parent Alternate Phone: (_____) _____
(Circle one) home work cell

Parent Email: _____

Emergency Contact Phone: (_____) _____
(Circle one) home work cell

Health/Accident Insurance Company: _____

Policy #: _____

SECTION B: HEALTH HISTORY (MAY BE COMPLETED BY PARENT/GUARDIAN) (Required)

PLEASE INDICATE **YES** OR **NO** FOR **ALL** AREAS

Yes	No	
☐	☐	Allergies: _____
☐	☐	Asthma
☐	☐	Blindness/Visual Problems (other than corrective lenses)
☐	☐	Bone or Joint Problem
☐	☐	Chest Pain
☐	☐	Concussion or Serious Head Injury: _____
☐	☐	Contact Lenses/Glasses
☐	☐	Diabetes
☐	☐	Down Syndrome ***(If Yes, see next page)***
☐	☐	Easy Bleeding
☐	☐	Heart Disease/Heart Defect/High Blood Pressure
☐	☐	Hearing Loss/Hearing Aid
☐	☐	Emotional/Psychiatric/Behavioral Problems

Medications: ☐ None ☐ Listed Below

Yes	No	
☐	☐	Heat Stroke/Exhaustion
☐	☐	Immunizations up-to-date
☐	☐	Major Surgery or Serious Illness _____
☐	☐	Non-verbal
☐	☐	Seizures/Epilepsy/Fainting Spells
☐	☐	Sickle Cell Trait or Disease
☐	☐	Special Diet _____
☐	☐	Uses Tobacco
☐	☐	Uses Wheelchair
☐	☐	Other: _____ *(for additional space, please see reverse side)*
☐	☐	Have you ever been convicted or charged with a criminal offense other than minor traffic violations?

☐ **BY CHECKING HERE,** I CONFIRM THAT I HAVE READ AND UNDERSTAND THE CONCUSSION AWARENESS & SAFETY RECOGNITION POLICY FOUND AT **www.specialolympicsminnesota.org/concussion-policy**

Medication Name	Dosage	Date Prescribed	Times per day	Medication Name	Dosage	Date Prescribed	Times per day

REQUIRED Signature of Parent/Guardian _____ Date: ____ / ____ / ____
Athletes can sign only if they are their own guardian.

Printed Name _____ Relationship to Athlete _____
(Required)

This form was updated August 2017.

ATHLETE NAME DATE OF BIRTH: _____ / _____ / _____

SECTION C: PHYSICAL EXAMINATION

Must be completed by a licensed medical practitioner - **ALL** boxes must be marked

Blood Pressure: _____/_____ Weight: _____ Height: _____

Normal	Abnormal		Normal	Abnormal		Normal	Abnormal	
☐	☐	Vision	☐	☐	Cardiovascular system	☐	☐	Cranial nerves
☐	☐	Hearing	☐	☐	Respiratory system	☐	☐	Coordination
☐	☐	Oral cavity	☐	☐	Gastrointestinal system	☐	☐	Reflexes
☐	☐	Neck	☐	☐	Genitourinary system			
☐	☐	Extremities	☐	☐	Skin			

Date of most recent tetanus immunization: ____/____/_____

In order to qualify to participate as a Special Olympics athlete, a person must be considered to have an intellectual disability or closely related developmental disability defined as functional limitations in both general learning and two or more adaptive skills areas: communication, leisure, self-direction, home living, community use, work, health and safety, academics, self-care and social skills. Persons whose functional limitations are based solely on a physical, behavioral, or emotional disability, or a specific learning or sensory disability, are not eligible to participate as Special Olympics athletes.

☐ **Yes** ☐ **No** **Does this person have an intellectual disability?**

Please list intellectual disability: _____

☐ **Yes** ☐ **No** **Does this athlete have Down syndrome?** Complete the information below.

☐ **Yes** ☐ **No** I have reviewed the above health information and have performed the above examination on this athlete within the past twelve (12) months and certify that the athlete can participate in Special Olympics.

Restrictions: _____

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: equestrian sports, gymnastics, diving, pentathlon, butterfly stroke and diving starts in swimming, high jump, alpine skiing, snowboarding, squat lift and soccer.

Yes	No	
☐	☐	Does the athlete participate in a restricted sport or event? If yes or unknown, an x-ray for atlanto-axial instability must be done.
☐	☐	Has an x-ray evaluation for atlanto-axial instability been done? Date: _____
☐	☐	If yes, was the x-ray positive for atlanto-axial instability? Positive indication is the atlanto-dens interval is 5mm or more.

Please list any additional information that may be helpful to know about this athlete: _____

_____

_____

*THE EXAMINER'S SIGNATURE, DATE OF EXAM AND CLINIC INFO BELOW ARE REQUIRED INFORMATION FOR SECTION C OF THIS APPLICATION TO BE COMPLETE. IF SUBMITTING AN ELECTRONICALLY GENERATED FORM, IT MUST CONTAIN INDICATION OF AN ELECTRONIC SIGNATURE AND THE CONTACT INFORMATION BELOW.

REQUIRED ***Examiner's Signature:** _____ *Date of exam: _____ / _____ / _____

*Examiner's Name: _____

*Clinic Name: _____

Address (City, State, Zip): _____

Phone: (_____) _____

ATHLETE NAME: _____ DATE OF BIRTH: _____ / _____ / _____

OFFICIAL SPECIAL OLYMPICS ATHLETE CONSENT FORM

☐ I, _____, am at least 18 years old and am my own legal guardian. *Please complete* **Section A only.**

☐ I, _____, am at least 18 years old but am NOT my legal guardian. *Please complete* **Section B only.**

Section A : CONSENT TO BE COMPLETED BY ADULT ATHLETE *(IF OWN GUARDIAN)*

I represent and warrant that, to the best of my knowledge and belief, I am physically and mentally able to participate in Special Olympics 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 which would preclude me from participating in Special Olympics. I understand that if I have Down Syndrome, I cannot participate in sports or events which, by their nature, result in hyper-extension, radical flexion or direct pressure on my neck or upper spine unless I have submitted the Special Consent for Athletes with Down Syndrome, available from the Special Olympics program in my state, or I have had a full radiological examination which established the absence of Atlanto-axial Instability. I am aware that if I choose not to complete the Special Consent for Athletes with Down Syndrome form which established the absence of Atlanto-axial Instability, I must have the radiological examination before I can participate in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in aquatics, high jump, alpine skiing, snowboarding, squat lift 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, magazines, Web site 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 be used for these purposes and activities.

I understand that the relationship between Special Olympics and me is an "at will" arrangement and such a relationship can be terminated at any time without cause by either Special Olympics or me.

If, during my participation in Special Olympics, 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 consent that I am signing. I understand that by signing this paper, I am saying that I agree to the provisions of this consent.

REQUIRED Signature of Adult Athlete _____ Date: _____ / _____ / _____

REQUIRED Signature of Witnessing Adult _____ Date: _____ / _____ / _____

Section B : CONSENT TO BE COMPLETED BY PARENT/GUARDIAN OF ATHLETE (Adult or Minor)

I am the parent/guardian of _____, 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 activities. 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, he/she 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 two physicians and myself have completed the official Special Consent for Athletes with Down Syndrome, available from the Special Olympics program in my state, or the athlete has had a full radiological examination which establishes the absence of Atlanto-axial Instability. I am aware that if I choose not to complete the Special Consent for Athletes with Down Syndrome form which established the absence of Atlanto-Instability, the athlete must have the radiological examination before he/she can participate in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in aquatics, 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, and words in television, radio, film, newspapers, magazines 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 personally 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, 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 consent, and have explained these provisions to the athlete. Through my signature on this consent form, I am agreeing to the above provisions on my own behalf and on the behalf of the athlete named above.

I understand that the relationship between Special Olympics and the athlete is an "at will" arrangement and such a relationship can be terminated at any time without cause by either Special Olympics or the athlete.

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

REQUIRED Signature of Parent/Guardian _____ Date: _____ / _____ / _____

Printed Name _____ Relationship to Athlete _____

ATHLETE NAME:_____ DATE OF BIRTH: _____ / _____ / _____

HEALTHY ATHLETES CONSENT FORM

Special Olympics Healthy Athletes

Special Olympics, Inc. offers non-invasive health care services to athletes at local, state, national and World Games venues through the Healthy Athletes program. These services have included individual screening assessments of health status and health care needs, provision of health education, routine preventive services (e.g. protective mouth guards), educational services, and, in the case of vision and hearing deficits, provision of needed eyewear (glasses, swim goggles, protective eyewear) and hearing aids. Athletes are informed as to their health status and advised as to the need for follow-up care. In addition, information collected at the time services are provided has been invaluable for developing policies, securing resources and implementing programs to better meet the health needs of athletes.

Such health services will be made available to Special Olympics athletes where offered through Healthy Athletes venues. Services may be offered in the following areas: vision; oral health; hearing; physical therapy; and a variety of health promotion areas (height, weight, sun protection, etc.). These services will be free of charge and are available to all Special Olympics athletes whether they are competing at the specific Games event or not. The services will be delivered by qualified health professionals who, in addition, have received Special Olympics-provided training. Many of the volunteer health professionals have previous experience in serving Special Olympics athletes and other special needs patients.

AUTHORIZATION FOR MINORS: I authorize the participation of _____ (athlete's full name) in the Healthy Athletes screening venues. I understand that participation in the Healthy Athletes venues is voluntary and that authorization can be withdrawn at any time without penalty and that participation in Healthy Athletes is not a requirement for participating in other Special Olympics activities. I understand that the provision of these health services is not intended as a substitute or alternative to regular care that has been received in the past or that may be recommended in the future. I understand that information that is gathered as part of the screening process may be used in group form (anonymously) to assess and communicate the overall health needs of athletes and to develop programs to address those needs.

_____ _____ / _____ / _____
Athlete's Printed Name Date of Birth

_____
Special Olympics Minnesota Delegation

REQUIRED Signature of Parent/Guardian _____ Date: _____ / _____ / _____
For athletes 17 years old and younger

REQUIRED Signature of Athlete _____ Date: _____ / _____ / _____
For athletes 18 years old and older

NOTE: This authorization shall remain effective unless the consenting party requests termination or the scope of the Healthy Athletes program changes materially.

Special Olympics Minnesota

Concussion Awareness & Safety Recognition Policy

Educational Material for Parents/Legal Guardians and Athletes

(Content Meets MDH Requirements)

Sources: Minnesota Department of Health. CDC and the National Operating Committee on Standards for Athletic Equipment (NOCSAE)

UNDERSTANDING CONCUSSION

Headache	Pressure in the Head	Nausea/Vomiting	Dizziness Sensitive
Balance Problems	Double Vision	Blurry Vision	to Light Fogginess
Sensitivity to Noise	Sluggishness Memory	Haziness	"Feeling Down"
Poor Concentration	Problems Feeling	Confusion	Sleep Problems Grogginess
Not "Feeling Right"	Irritable	Slow Reaction Time	

WHAT IS A CONCUSSION?

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a fall, bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. A concussion can be caused by a shaking, spinning or a sudden stopping and starting of the head. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious. A concussion can happen even if you haven't been knocked out.

You can't see a concussion. Signs and symptoms of concussions can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If the athlete reports any symptoms of a concussion, or if you notice symptoms yourself, seek medical attention right away. An athlete who may have had a concussion should not return to play on the day of the injury and until a health care professional says they are okay to return to play.

IF YOU SUSPECT A CONCUSSION:

1. **SEEK MEDICAL ATTENTION RIGHT AWAY -** A health care professional will be able to decide how serious the concussion is and when it is safe for the athlete to return to regular activities, including sports. Don't hide it, report it. Ignoring symptoms and trying to "tough it out" often makes it worse.

2. **KEEPING YOUR ATHLETE OUT OF PLAY -** Concussions take time to heal. Don't let the athlete return to play the day of injury and until a health care professional says it's okay. An athlete who returns to play too soon, while the brain is still healing, risks a greater chance of having a second concussion. Young children and teens are more likely to get a concussion and take longer to recover than adults. Repeat or second concussions increase the time it takes to recover and can be very serious. They can cause permanent brain damage, affecting the athlete for lifetime. They can be fatal. It is better to miss one game than the whole season.

3. **TELL THE COACH ABOUT ANY PREVIOUS CONCUSSION** – Coaches should know if an athlete had a previous concussion. An athlete's coach may not know about a concussion received in another sport or activity unless you notify them.

SIGNS OBSERVED BY PARENTS/LEGAL GUARDIANS:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Can't recall events prior to or after a hit
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood or behavior, or personality changes

CONCUSSION DANGER SIGNS:

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. An athlete should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people/places
- Becomes increasingly confused
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously.)

HOW TO RESPOND TO A REPORT OF A CONCUSSION:

If an athlete reports one or more symptoms of a concussion after a bump, blow, or jolt to the head or body, s/he should be kept out of athletic play the day of the injury. The athlete should only return to play with permission from a health care professional experienced in evaluating for concussion. During recovery, rest is key. Exercising or activities that involve a lot of concentration (such as studying, working on the computer, or playing video games) may cause concussion symptoms to reappear or get worse. Athletes who return to sports after a concussion may need to take rests breaks and be given extra help and time. After a concussion, returning to sports is a gradual process that should be monitored by a health care professional. **If a concussion is diagnosed, the athlete must sit out for a minimum of 7 consecutive days AND a healthcare provider must provide written clearence for the athlete to return to play.**

Remember: Concussion affects people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer
To learn more, go to www.cdc.gov/concussion.

Please check the box located on page 1 of this Application for Participation in Special Olympics packet indicating that you have read and understand the above Concussion Awareness Policy.

Special Olympics Minnesota
900 2nd Avenue South, Ste 300, Minneapolis, MN 55402 **Phone:** 800.783.7732 **Fax:** 612.333.8782
SOMN.ORG