ATHLETE REGISTRATION FORM

SOOK Team: ______________________ **Coach Name** ______________________

Coach Cell # ______________________ **Coach Email** ______________________

ATHLETE INFORMATION		
First Name:	**Middle Name:**	
Last Name:	**Preferred Name:**	
Date of Birth (mm/dd/yyyy):	☐ Female ☐ Male	
Race/Ethnicity (Optional): ☐ American Indian/Alaskan Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ White ☐ Two or More Races		
Athlete's Area Name & City:		
Street Address:		
City:	**State:**	**Postal Code:**
Phone:	**E-mail:**	
Sports/Activities:		
Athlete Employer, if any (Optional):		
Does the athlete have the capacity to consent to medical treatment on his or her own behalf? ☐ Yes ☐ No		
PARENT / GUARDIAN INFORMATION		
Name:		
Relationship:		
☐ **Same Contact Info as Athlete**		
Street Address:		
City:	**State:**	**Postal Code:**
Phone:	**E-mail:**	
EMERGENCY CONTACT INFORMATION		
☐ **Same as Parent/Guardian**		
Name:		
Phone:	**Relationship:**	
PHYSICIAN & INSURANCE INFORMATION		
Physician Name - PRINT:		
Physician Phone:		
Insurance Company:	**Insurance Policy Number:**	
Insurance Group Number:		

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.** Special Olympics Oklahoma and their sponsors and partners have my permission to use my likeness, photo, video, name, voice and words in either television, radio, film, newspapers, magazines and other social media, and in any form, for the purpose of advertising or communicating the purposes and activities of Special Olympics and/or fundraising efforts to support those purposes and activities. I understand neither the athlete or his/her family will be compensated for the use of his/her likeness.
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 parent/guardian is unavailable, to consent or make medical decisions in an emergency, I authorize Special Olympics to seek medical care on my behalf and take whatever measures necessary to protect my health and well-being, including, if necessary, hospitalization.
5. **Overnight Stay.** I acknowledge, understand and have read the SOOK Housing Policy concerning overnight travel & lodging that is available on the www.sook.org website.
6. **Health Programs.** By signing below, I consent to my participation in the Healthy Athletes Program. I understand that I should seek independent medical advice and assistance as I, or my parent/guardians, are responsible for my health.
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; share competition results; 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.
     - sharing my personal information with medical professionals in an emergency,
   - *Sharing of Personal Information.* Personal information may be shared consistent with this form and as further explained in the Special Olympics privacy policy at www.SpecialOlympics.org/Privacy_Policy.aspx.

Athlete Name:	**E-mail:**
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:**

Athlete Medical Form – **HEALTH HISTORY**

Valid June 1, 2019 thru May 31, 2022

Special Olympics Oklahoma

Athlete First & Last Name:____

Athlete Date of Birth (mm/dd/yyyy):____ Female Male

TEAM: ____ **COACH:**____

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:______________________________________

ASSIST⇒J9 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	**Depression** *(diagnosed)*	No	Yes
Aggressive behavior during the past year	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:

Athlete Medical Form – **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

Athlete Medical Form – **PHYSICAL EXAM**

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

Athlete's First and Last Name:____

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 better No Yes N/A
in	lbs	Body Fat %	F					Left Vision 20/40 or better No Yes N/A

Right Hearing (Finger Rub)	Responds	No Response	Can't Evaluate	
Left Hearing (Finger Rub)	Responds	No Response	Can't Evaluate	
Right Ear Canal	Clear	Cerumen	Foreign Body	
Left Ear Canal	Clear	Cerumen	Foreign Body	
Right Tympanic Membrane	Clear	Perforation	Infection	NA
Left Tympanic Membrane	Clear	Perforation	Infection	NA
Oral Hygiene	Good	Fair	Poor	
Thyroid Enlargement	No	Yes		
Lymph Node Enlargement	No	Yes		
Heart Murmur (supine)	No	1/6 or 2/6	3/6 or greater	
Heart Murmur (upright)	No	1/6 or 2/6	3/6 or greater	
Heart Rhythm	Regular	Irregular		
Lungs	Clear	Not clear		
Right Leg Edema	No	1+ 2+	3+	4+
Left Leg Edema	No	1+ 2+	3+	4+
Radial Pulse Symmetry	Yes	R>L	L>R	
Cyanosis	No	Yes, describe		
Clubbing	No	Yes, describe		

Bowel Sounds	Yes	No		
Hepatomegaly	No	Yes		
Splenomegaly	No	Yes		
Abdominal Tenderness	No	RUQ	RLQ	LUQ LLQ
Kidney Tenderness	No	Right	Left	
Right upper extremity reflex	Normal	Diminished	Hyperreflexia	
Left upper extremity reflex	Normal	Diminished	Hyperreflexia	
Right lower extremity reflex	Normal	Diminished	Hyperreflexia	
Left lower extremity reflex	Normal	Diminished	Hyperreflexia	
Abnormal Gait	No	Yes, describe below		
Spasticity	No	Yes, describe below		
Tremor	No	Yes, describe below		
Neck & Back Mobility	Full	Not full, describe below		
Upper Extremity Mobility	Full	Not full, describe below		
Lower Extremity Mobility	Full	Not full, describe below		
Upper Extremity Strength	Full	Not full, describe below		
Lower Extremity Strength	Full	Not full, describe below		
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	Acute Infection	O_2 Saturation Less than 90% on Room Air
Concerning Neurological Exam	Stage II Hypertension or Greater	Hepatomegaly or Splenomegaly
Other, please describe:		

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

Follow up with a cardiologist	Follow up with a neurologist	Follow up with a primary care physician
Follow up with a vision specialist	Follow up with a hearing specialist	Follow up with a dentist or dental hygienist
Follow up with a podiatrist	Follow up with a physical therapist	Follow up with a nutritionist

Other/Exam Notes:

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

Athlete Medical Form – **MEDICAL REFERRAL FORM**

(To be completed by a Licensed Medical Professional only if referral is needed)

Athlete's First and Last Name:____

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.

Examiner's Name:____

Specialty:____

I have been asked to perform an additional athlete exam for the following medical concern(s) - *Please describe:*

Concerning Cardiac Exam | Acute Infection | O_2 Saturation Less than 90% on Room Air

Concerning Neurological Exam | Stage II Hypertension or Greater | Hepatomegaly or Splenomegaly

Other, please describe:

In my professional opinion, this athlete MAY now participate in Special Olympics sports (indicate restrictions or limitations below):

Yes | **Yes, but with restrictions** ***(list below)*** | **No**

Additional Examiner Notes/Restrictions:

Examiner E-mail: ____

Examiner Phone: ____

License: ____

Examiner's Signature	**Date**

This section to be completed by Special Olympics staff only, if applicable.

This medical exam was completed at a MedFest event? Yes No

The athlete is a Unified Partner or a Young Athlete Participant? Unified Partner Young Athlete

Special Olympics
Oklahoma

ATLANTO-AXIAL INSTABILITY (AAI) SPECIAL RELEASE FORM

(SPECIAL RELEASE CONCERNING SPINAL CORD COMPRESSION AND ATLANTOAXIAL INSTABILITY)

This page only needs to be completed if symptoms of spinal cord compression or Atlantoaxial instability are present.

- Only complete this form if symptoms of spinal cord compression or Atlantoaxial instability were found in a pre-participation examination and a doctor then provided clearance for participation following a neurological evaluation.

I agree to the following:

1. **Spinal Cord Compression Symptoms.** In a pre-participation examination, a licensed medical professional found symptoms that might be the result of spinal cord compression or Atlantoaxial instability.

2. **Neurological Evaluation.** After a neurological evaluation, a qualified doctor concluded that:
    - The cause of the symptoms will not result in additional risk of neurological injury due to participation in sports, and
    - Participation in Special Olympics activities is safe without restrictions or with restrictions that will be shared with Special Olympics and followed.

3. **Liability Release.** I acknowledge that I have been informed of the findings and determinations of the physician. I release and hold harmless Special Olympics from all claims in connection with possible spinal cord compression or Atlantoaxial instability. For this form, “Special Olympics” means all Special Olympics organizations.

Athlete Name:	**E-mail:**
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. This release shall be binding upon me, the athlete and our respective heirs and legal representatives.	
Parent/Guardian Signature:	**Date:**
Printed Name:	**Relationship:**