Hood River

Local Program

Special Olympics Oregon

Hood River

School Code

APPLICATION FOR PARTICIPATION (MEDICAL FORM)

BASIC INFORMATION

Check here if New Athlete ☐ | *Parents/Guardian – Keep a copy of this* | ***ALL SIGNATURES ARE REQUIRED***

First Name | Last Name | Male ☐ Female ☐ Other ☐

Race/Ethnicity (*Optional*)
☐ Asian/Pacfic Isl. ☐ Black ☐ Hispanic ☐ Mid-Eastern ☐ Native Amer ☐ White ☐ Multiracial ☐ Other

Date of Birth *(mm/dd/yyyy)* ___/___/___

Street Address/PO Box | Apt #

City/Town | State | ZIP Code + 4

Home Phone # or Cell # (circle one) ___-___-___ | Email Address

Parent/Guardian Contact Name | Parent/Guardian Home Phone # or Cell (circle one) ___-___-___

Emergency Contact Name (if other than parent/guardian) | Emergency Contact Cell Phone # ___-___-___

HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER

Health/Accident Insurance Company _____ Policy # _____

Yes	No		Yes	No	
☐	☐	Heart disease / heart defect / high blood pressure			Allergy/Issues:
☐	☐	Chest pain	☐	☐	General:
☐	☐	Seizures / epilepsy / fainting spells	☐	☐	Medicines:
☐	☐	Diabetes	☐	☐	Food:
☐	☐	Concussion or serious head injury	☐	☐	Insect stings / bites:
☐	☐	Major surgery or serious illness	☐	☐	Special diet:
☐	☐	Heat stroke / exhaustion	☐	☐	Asthma:
☐	☐	Blindness / visual problem	☐	☐	Emotional / psychiatric / behavioral / requires extra supervision
☐	☐	Contact lenses / glasses	☐	☐	Has the athlete had a tetanus shot in the past 7 years?
☐	☐	Hearing loss / hearing aid	☐	☐	Requires a wheelchair
☐	☐	Bone or joint problem			
☐	☐	Currently on Medication ***(If yes, please complete the attached medication list')***			

ATLANTO-AXIAL INSTABILITY ASSESSMENT FOR ATHLETES WITH DOWN SYNDROME

EXAMINER'S NOTE: SOOR requires persons with Down Syndrome to have 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.

Yes	No	
☐	☐	Has an X-ray evaluation for Atlanto-Axial Instability been done? Date of x-ray: _____/_____/_____
☐	☐	If yes, was it positive for Atlanto-Axial Instability? (positive indicates that the atlanto-dens interval is 5mm or more)

PHYSICAL EXAMINATION: TO BE COMPLETED BY HEALTH CARE PROVIDER *(not fillable)*

Primary ID Etiology/Category (if known) | Height: | Weight: | BMI

PLEASE CIRCLE ANY RESTRICTED SPORTS FOR THIS ATHLETE: Alpine Ski, Aquatics, Diving Starts in Aquatics, Athletics (Track & Field), Basketball, Bocce, Bowling, Cross-Country Ski, Golf, Gymnastics, Long-Distance Running, Power-Lifting, Snowboard, Snowshoe, Soccer, Softball, Volleyball – Other (please list) RESTRICTIONS: _____

I have reviewed the above health information and examined the Athlete named in this application and certify that there is no medical evidence available which would preclude this Athlete from participating in Special Olympics.

_____ _____/_____/_____

EXAMINER'S SIGNATURE **EXAM DATE**

(*no office stamps accepted without provider's signature*)

Examiner's Name | Street Address or P.O.

Phone # ___-___-___ | City/Town | State | ZIP

Please return this application to: Special Olympics Oregon Hood River, PO Box 989 Hood River, OR 97031

Email: hoodriver@soor.org | Website: https://soor.org/program/hoodriver/

Special Olympics Oregon

APPLICATION FOR PARTICIPATION (MEDICAL FORM)

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**. I give permission to Special Olympics, Inc., Special Olympics games organizing committees, Special Olympics accredited Programs, and Special Olympics Oregon (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. Special Olympics and its sponsors and partners will not use my Likeness to endorse commercial products or services. I understand I will not be compensated for the use of my 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 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.
   - ☐ I do not consent to blood transfusions.

   (If either box is marked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)
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 www.specialolympics.org/privacy-policy.

ATHLETE RELEASE: TO BE COMPLETED BY ATHLETE OVER 18

I, the athlete named above, have read this consent form and fully understand (or have had someone to fully explain to me) the provisions of the release that I am signing. I understand that by signing, I am agreeing to all the provisions of this release. I hereby agree that I will be bound thereby and I shall defend you and hold you harmless for any disaffirmation thereof.

_____ ____/____/____

Signature of *adult* athlete (over 18): **Date:**

ATHLETE RELEASE: TO BE COMPLETED BY PARENT/GUARDIAN OF MINOR ATHLETE

For Parent/Guardian of Athlete (if Athlete is under 18 years old): 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 the release and has agreed to its terms.

_____ _____ ____/____/____

Print Name: **Relationship to athlete:** **Date:**

As parent or legal guardian of the athlete named above, have read this consent form and fully understand the provisions of the above release form. I understand that by signing, I am agreeing to all the provisions of this release. I hereby agree that I and said person will be bound thereby and I shall defend you and hold you harmless for any disaffirmation thereof by said person

_____ ____/____/____

Signature of Parent/Guardian (for Athlete under 18) **Date**:

Please return this application to:

Special Olympics Oregon Hood River
PO Box 989
Hood River, OR 97031

Special Olympics Oregon

SOOR ATHLETE MEDICATION LIST

First Name: _____ Last Name: _____

Local Program/County: _____

ALL CURRENT MEDICATION INFORMATION MUST BE LISTED BELOW.

Medication Name	Medication Dosage	Times Per Day	Side Effects Noted

If you have listed medications, please return this medication list with the Application for Participation (Medical) to:

Special Olympics Oregon Hood River

PO Box 989

Hood River, OR 97031

Or via email: hoodriver@soor.org