Dear Special Olympics Athletes, Parents, and Guardians:

Through the power of sports, our athletes find joy, confidence and fulfillment — on the playing field and in life. Whether you are new to Special Olympics or have been involved for years, we are excited you are part of the movement!

To register or re-register as a Special Olympics athlete, please complete the enclosed forms:

☐ **REGISTRATION FORM.** This form asks for contact and other information.

☐ **RELEASE FORM.** This form goes over some important details about Special Olympics participation.

☐ **OPTIONAL LIKENESS RELEASE FOR SPONSORS.** If you would like to allow Special Olympics sponsors to use your photos, videos and stories, you may sign this form. This form is optional.

☐ **MEDICAL FORM.** This form is designed to identify health concerns that are more common among people with intellectual disabilities and clear an athlete to participate. Please fill out the Health History section on pages 1 and 2. If you do not understand any parts of the form, you may leave those parts blank to be discussed during the exam. The Physical Exam section on page 3 should be filled out and signed by a licensed medical professional (for example, Physician, Registered Nurse Practitioner, or Physician Assistant).

**PLEASE SUBMIT REGISTRATION PACKET TO YOUR AREA TEAM LEADER**
# ATHLETE REGISTRATION FORM

State Special Olympics Program: ____________________________________________

Are you a new athlete to Special Olympics or Re-Registering?  
☐ New Athlete  ☐ Re-Registering

## ATHLETE INFORMATION

<table>
<thead>
<tr>
<th>First Name:</th>
<th>Middle Name:</th>
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<table>
<thead>
<tr>
<th>Last Name:</th>
<th>Preferred Name:</th>
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</table>

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

Race/Ethnicity (Optional):

- ☐ American Indian/Alaskan Native
- ☐ Black or African American
- ☐ White
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Hispanic or Latino (specific origin group:_________________________)
- ☐ Two or More Races

Language(s) Spoken in Athlete’s Home (Optional):  Check all that apply

- ☐ English
- ☐ Spanish
- ☐ Other (please list):

Street Address:

<table>
<thead>
<tr>
<th>City:</th>
<th>State:</th>
<th>Postal Code:</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

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 (required if minor or otherwise has a legal guardian)

Name:

<table>
<thead>
<tr>
<th>Relationship:</th>
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</tbody>
</table>

☐ Same Contact Info as Athlete

Street Address:

<table>
<thead>
<tr>
<th>City:</th>
<th>State:</th>
<th>Postal Code:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Phone:  
E-mail:

EMERGENCY CONTACT INFORMATION

☐ Same as Parent/Guardian

Name:

Phone:  
Relationship:

## PHYSICIAN & INSURANCE INFORMATION

Physician Name:

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.** I give permission to Special Olympics, Inc., Special Olympics games organizing committees, and Special Olympics accredited Programs (collectively “Special Olympics”) to use my likeness, photo, video, name, voice, and words to promote Special Olympics and raise funds for Special Olympics.

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. (Not common.)
   - I do not consent to blood transfusions. (Not common.)
   (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:
     o 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.
     o using my personal information and creating a profile of me for communications and marketing purposes, including direct digital marketing through email, SMS, social media, and other channels.
     o sharing my personal information with (i) researchers, business partners, public health agencies, and other organizations 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 understand Special Olympics is a global organization with headquarters in the United States of America. I acknowledge that my personal information may be stored and processed in countries outside my country of residence, including the United States. Such countries may not have the same level of personal data protection as my country of residence, and I agree that the laws of the United States will govern your processing of my personal information as provided in this consent.
   - 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.
   - 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.

<table>
<thead>
<tr>
<th>Athlete Name:</th>
<th>E-mail:</th>
</tr>
</thead>
</table>

**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.

<table>
<thead>
<tr>
<th>Athlete Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

**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.

<table>
<thead>
<tr>
<th>Parent/Guardian Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Printed Name:</th>
<th>Relationship:</th>
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</thead>
</table>
Special Olympics relies on sponsors and partners to help support our mission. We often use photos, videos and stories of our athletes to show the impact of support by companies that sponsor Special Olympics. If you wish to allow your likeness to be used in this way, please read and sign below.

I agree to the following:

- I give permission to Special Olympics, Inc., Special Olympics games organizing committees, and Special Olympics accredited Programs (collectively "Special Olympics") and their sponsors and partners to use my likeness, photo, video, name, voice, and words ("my likeness") to acknowledge the sponsors' and partners' support 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.

<table>
<thead>
<tr>
<th>Athlete Name:</th>
<th>E-mail:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ATHLETE SIGNATURE</strong> (required for adult athlete with capacity to sign legal documents)</td>
<td></td>
</tr>
<tr>
<td>I have read and understand this form. If I have questions, I will ask. By signing, I agree to this form.</td>
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</tr>
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<td>Date:</td>
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</tr>
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<td>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.</td>
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</tr>
<tr>
<td>Parent/Guardian Signature:</td>
<td>Date:</td>
</tr>
<tr>
<td>Printed Name:</td>
<td>Relationship:</td>
</tr>
</tbody>
</table>
# Medical Form for US Programs

**Athlete Medical Form**

*(To be completed by the athlete or parent/guardian/caregiver and brought to exam)*

**Athlete First & Last Name:** ___________________________  **Preferred Name:** ___________________________

**Athlete Date of Birth (mm/dd/yyyy):** ___________________________  

**Female** [ ]  **Male** [ ]

**STATE PROGRAM:** ___________________________  **E-mail:** ___________________________

### 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: __________________________________________

**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)?**

- [ ] 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:** __________________________________________

---

Medical Form for US Programs – updated July 2017  

Special Olympics Medical Form  | 1 of 4
HAS THE ATHLETE EVER BEEN DIAGNOSED WITH OR EXPERIENCED ANY OF THE FOLLOWING CONDITIONS

<table>
<thead>
<tr>
<th>Condition</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of Consciousness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dizziness during or after exercise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headache during or after exercise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest pain during or after exercise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shortness of breath during or after exercise</td>
<td></td>
<td></td>
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<tr>
<td>Irregular, racing or skipped heart beats</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Congenital Heart Defect</td>
<td></td>
<td></td>
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<tr>
<td>Heart Attack</td>
<td></td>
<td></td>
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<tr>
<td>Cardiomyopathy</td>
<td></td>
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<tr>
<td>Heart Valve Disease</td>
<td></td>
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<tr>
<td>Heart Murmur</td>
<td></td>
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</tr>
<tr>
<td>Endocarditis</td>
<td></td>
<td></td>
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<tr>
<td>Stroke/TIA</td>
<td></td>
<td></td>
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<tr>
<td>Concussions</td>
<td></td>
<td></td>
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<tr>
<td>Asthma</td>
<td></td>
<td></td>
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<tr>
<td>Hearing Impairment</td>
<td></td>
<td></td>
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<tr>
<td>Enlarged Spleen</td>
<td></td>
<td></td>
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<tr>
<td>Single Kidney</td>
<td></td>
<td></td>
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<tr>
<td>Osteoporosis</td>
<td></td>
<td></td>
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<tr>
<td>Sickle Cell Disease</td>
<td></td>
<td></td>
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<tr>
<td>Sickle Cell Trait</td>
<td></td>
<td></td>
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<tr>
<td>Easy Bleeding</td>
<td></td>
<td></td>
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<tr>
<td>Spina Bifida</td>
<td></td>
<td></td>
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<tr>
<td>Single Kidney</td>
<td></td>
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<tr>
<td>Osteopenia</td>
<td></td>
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<tr>
<td>Arthritis</td>
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<tr>
<td>Sickle Cell Disease</td>
<td></td>
<td></td>
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<tr>
<td>Heat Illness</td>
<td></td>
<td></td>
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<tr>
<td>Broken Bones</td>
<td></td>
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<tr>
<td>Dislocated Joints</td>
<td></td>
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</tr>
</tbody>
</table>

Describe any past broken bones or dislocated joints (if yes is checked for either of those fields above):

If female athlete, list date of last menstrual period:

List any other ongoing or past medical conditions:

### Neurological Symptoms for Spinal Cord Compression and Atlanto-axial Instability

<table>
<thead>
<tr>
<th>Symptom</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty controlling bowels or bladder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbness or tingling in legs, arms, hands or feet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weakness in legs, arms, hands or feet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head Tilt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spasticity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paralysis</td>
<td></td>
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</tbody>
</table>

If yes, is this new or worse in the past 3 years?

PLEASE LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW (includes inhalers, birth control or hormone therapy)

<table>
<thead>
<tr>
<th>Medication, Vitamin or Supplement Name</th>
<th>Dosage</th>
<th>Times per Day</th>
<th>Medication, Vitamin or Supplement Name</th>
<th>Dosage</th>
<th>Times per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Is the athlete able to administer his or her own medications?

| No | Yes |

Name of Person Completing this Form | Relationship to Athlete | Phone | Email

Medical Form for US Programs – updated July 2017
## Medical Form - PHYSICAL EXAM

### 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)

<table>
<thead>
<tr>
<th>Height (cm)</th>
<th>Weight (kg)</th>
<th>BMI (optional)</th>
<th>Temperature</th>
<th>Pulse</th>
<th>O₂Sat</th>
<th>Blood Pressure (in mmHg)</th>
<th>Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>BP Right:</td>
<td>Right Vision</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>BP Left:</td>
<td>20/40 or better</td>
</tr>
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<td>No</td>
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<td>Yes</td>
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<td>N/A</td>
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<td></td>
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<td></td>
<td></td>
<td>Left Vision</td>
<td>20/40 or better</td>
</tr>
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<td>Yes</td>
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<td></td>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>

Right Hearing (Finger Rub)  
Responds: No  
Response: No  
Can’t Evaluate: No  

Left Hearing (Finger Rub)  
Responds: No  
Response: No  
Can’t Evaluate: No  

Right Ear Canal  
Clear: Yes  
Cerumen: No  
Foreign Body: No  

Left Ear Canal  
Clear: Yes  
Cerumen: No  
Foreign Body: No  

Right Tympanic Membrane  
Clear: Yes  
Perforation: No  
Infection: No  
NA: No  

Left Tympanic Membrane  
Clear: Yes  
Perforation: No  
Infection: No  
NA: No  

Oral Hygiene  
Good: Yes  
Fair: No  
Poor: No  

Thyroid Enlargement  
No: Yes  

Lymph Node Enlargement  
No: Yes  

Heart Murmur (supine)  
No: Yes  
1/6 or 2/6: No  
3/6 or greater: No  

Heart Murmur (upright)  
No: Yes  
1/6 or 2/6: No  
3/6 or greater: No  

Heart Rhythm  
Regular: Yes  
Irregular: No  

Lungs  
Clear: Yes  
Not clear: No  

Right Leg Edema  
No: Yes  
1+: Yes  
2+: Yes  
3+: Yes  
4+: Yes  

Left Leg Edema  
No: Yes  
1+: Yes  
2+: Yes  
3+: Yes  
4+: Yes  

Radial Pulse Symmetry  
Yes: Yes  
R=L: Yes  
L>R: No  

Cyanosis  
No: Yes  

Clubbing  
No: Yes  

Bowel Sounds  
No: Yes  

Hepatomegaly  
No: Yes  

Splenomegaly  
No: Yes  

Abdominal Tenderness  
No: Yes  

Kidney Tenderness  
No: Yes  

Right upper extremity reflex  
Normal: Yes  
Diminished: No  
Hyperreflexia: No  

Left upper extremity reflex  
Normal: Yes  
Diminished: No  
Hyperreflexia: No  

Right lower extremity reflex  
Normal: Yes  
Diminished: No  
Hyperreflexia: No  

Left lower extremity reflex  
Normal: Yes  
Diminished: No  
Hyperreflexia: No  

Abnormal Gait  
No: Yes  

Spasticity  
No: Yes  

Tremor  
No: Yes  

Loss of Sensitivity  
No: Yes  

Abnormal Reflexes:  


### 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.  
- □ 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 this time & MUST be further evaluated by a physician for the following concerns:

- Concerning Cardiac Exam  
- Concerning Neurological Exam  
- 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: ________________________________

Special Olympics Medical Form | 3 of 4
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  ☐ O₂ 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