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 New  or Update

# APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS GEORGIA

Valid Application for Participation is mandatory for all training and competitions

4000 Dekalb Technology Parkway • Building 400, Suite 400 • Atlanta, Georgia 30340 • 770-414-9390 • Fax: 770-216-8339

Athlete Name \_\_\_\_\_

Area \_\_\_\_\_ Agency \_\_\_\_\_

## SECTION A: ATHLETE HEALTH INFORMATION (SHOULD BE SUBMITTED EVERY 3 YEARS)

Social Security Number (Athlete)    -          
*Required For Identification Only*

Athlete's Name (last name, space, first name)

**Birthdate**  
 M M D D Y Y Sex (M or F)

Agency Name

Is the athlete employed?  Yes  No  
 If so, where? \_\_\_\_\_

Athlete's Mailing Address

Background (optional):  
 African American  Caucasian  Hispanic  Native American  
 Other \_\_\_\_\_

Athlete's City

State  Zip Code  Parent's/Guardian's Daytime Telephone    -

Emergency Contact \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
*Required for emergency purposes*

### HEALTH INSURANCE & EMERGENCY INFORMATION

Medicaid Number \_\_\_\_\_ Health Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

### PARENT OR GUARDIAN AUTHORIZATION AND MEDIA RELEASE

On my own behalf or as the undersigned parent or legal guardian of the above named athlete, hereby request permission for the athlete to participate in the Special Olympics Program. I represent and warrant to you that the athlete is physically and mentally able to participate in Special Olympics, and I submit herewith a subscribed medical certificate. 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 a full radiological examination establishes the absence of Atlanto-axial Instability. I am aware that the sports and events for which the radiological examination is required are equestrian sports, artistic gymnastics, diving, pentathlon, high jump, alpine skiing, soccer, and butterfly stroke and diving starts in swimming. On behalf of the athlete and myself, I acknowledge that the athlete will be using facilities at his/her own risk and I, on my own behalf, hereby release, discharge and indemnify Special Olympics from all liability for injury to person or damage to property of myself and the athlete. In permitting the athlete to participate, I am specially granting permission to Special Olympics Georgia to use the name, likeness, voice and words of the athlete in television, radio, films, newspapers, magazines and other media, and in any form not heretofore described, for the purpose of advertising or communicating the purpose and activities of Special Olympics and in appealing for funds to support such activities. If I am not personally present at Special Olympics activities in which the athlete is to compete, so as to be consulted in case of necessity, you are authorized on my behalf and at my account to take such measures and arrange for such medical and hospital treatment as you may deem advisable for the health and well-being of the athlete. By signing this form I authorize Special Olympics and/or its agents to make an independent investigation of my background, references, character, past employment, education, credit history, criminal or police records, including those maintained by both public and private organizations and all public records for the purpose of confirming the information contained on my application. I understand that by signing below I consent to participate in the Special Olympics Healthy Athletes program that provides individual screening assessments of health status and health care needs in the areas of: vision; oral health; hearing; physical therapy; and a variety of health promotion areas (height, weight, sun protection, etc.). I understand there is no obligation for me to participate in the Healthy Athletes Program should I decide not to participate.

**I, THE UNDERSIGNED ADULT ATHLETE,** have read and fully understand the provisions of the above release and/or have had them explained. I hereby agree that I will be bound thereby and shall defend Special Olympics Georgia and hold it harmless from disaffirmation thereof. I acknowledge and agree that the above information is accurate.

**I, THE UNDERSIGNED PARENT OR GUARDIAN** of the above specified athlete, have read and fully understand the provisions of the above release and have explained them to said athlete. I hereby, agree that I and said minor will be bound thereby, and I shall defend Special Olympics Georgia and hold it harmless from disaffirmation thereof by said minor. I acknowledge and agree that the above information is accurate.

Athlete \_\_\_\_\_  
 Witness \_\_\_\_\_ Date \_\_\_\_\_  
 (Family member, coach, teacher, friend)

Signature of Parent and/or Legal Guardian \_\_\_\_\_  
 Print Name \_\_\_\_\_ Date \_\_\_\_\_

### MEDICAL CLEARANCE

PLEASE CHECK MEDICAL INFORMATION

- Does the athlete have:
- Heart Problems Yes  No
  - Diabetes Yes  No
  - Seizures/Epilepsy Yes  No
  - Major Surgery/Serious Illness Yes  No
  - Parent/Sibling (under 40) died of heart disease Yes  No
  - Down Syndrome Yes  No
- If athlete is Down Syndrome, have x-rays of the C1-C2 vertebrae been taken and examined?  
 Yes  No
- Date of x-ray \_\_\_\_\_  
 Does the athlete have Atlanto-axial Instability? Yes  No
- Vision Problems/Blind Yes  No
  - Hearing Loss/Deaf Yes  No
  - Does athlete use wheelchair? Yes  No

Other \_\_\_\_\_

Current Medications Dosage  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Allergies (Medication, Food, Insect Bites):  
 \_\_\_\_\_  
 \_\_\_\_\_

Date of Last Tetanus Shot: \_\_\_\_\_

**\*A PHYSICAL EXAMINATION BY A LICENSED EXAMINER IS REQUIRED EVERY 3 YEARS FOR ATHLETES WITH "YES" CHECKED ON 1-5\***

### SECTION B MEDICAL CERTIFICATION

I have examined the above named athlete and, in my opinion, there is no mental or physical reason why he or she should not participate in the Special Olympics sports training competition program. Further information will be forwarded if required. Current medication, if any, is specified with dosage on this application.

COMMENTS \_\_\_\_\_  
 \_\_\_\_\_  
 Examination Date \_\_\_\_\_  
 Signature \_\_\_\_\_  
 Print Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_

**\*A PHYSICAL EXAMINATION PERFORMED BY A LICENSED EXAMINER IS REQUIRED FOR INITIAL PARTICIPATION\***