



232 East 2nd Street, Suite 201
 Casper, WY 82601
 (307) 235-3062 telephone
 (307) 235-3063 fax
 www.specialolympicswy.org

APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS WYOMING (Medical Form for individuals with intellectual disabilities)

Please print clearly and complete ALL sections in their entirety
This application expires three (3) years from the date of the physical exam

DEMOGRAPHICS

Local Program _____ Application: (circle one) **NEW** **RENEWAL**

Athlete Information: Last Name: _____ First Name: _____
 Gender: Male _____ Female _____ Date of Birth: ____/____/____
Month Day Year
 Street Address: _____
 City: _____ State: _____ Zip: _____
 Primary Phone: _____
 Alternate Phone: _____
 Email Address: _____
 Add email address to SOWY Newsletter mailing list

Parent/Guardian Information: Name: _____
 Street Address (if different than Athlete): _____
 City: _____ State: _____ Zip: _____
 Primary Phone: _____
 Alternate Phone: _____
 Email Address: _____
 Add email address to SOWY Newsletter mailing list

Emergency Contact (if other than parent/guardian): _____ **Phone:** _____
Health/Accident Insurance Company: _____ **Policy Number:** _____

HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER

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Allergies (list specific): Food _____ Medication _____ General/Insect sting/bites _____
 Special Diet _____ Date of last tetanus immunization: ____/____/____ Other: _____

Medications: Is the athlete taking any prescription medications? Yes No If yes, please list all medications below.

Please print medication name, amount, date prescribed and number of times per day medication is given. (Use separate sheet for additional space).

Medication Name	Dosage	Date Prescribed	Times Per Day	Medication Name	Dosage	Date Prescribed	Times Per Day

SIGNATURE OF PERSON COMPLETING THIS FORM (PARENT/GUARDIAN/ADULT ATHLETE): _____
ALSO PRINT NAME: _____ **DATE:** ____/____/____

ATLANTO-AXIAL INSTABILITY ASSESSMENT FOR ATHLETES WITH DOWN SYNDROME

PHYSICIAN'S NOTE: If the athlete has Down syndrome, Special Olympics requires a full radiological examination establishing the absence of Atlanto-axial Instability and the completion of the Special Examination Form before he/she may participate in sports or events which, by their nature, may result in hyper-extension, radical flexion or direct pressure on the neck or upper spine.

YES NO

Does the athlete have Down Syndrome
 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)

*The sports and events for which such a radiological examination is required are: Judo, Equestrian sports, Gymnastics, Diving, Pentathlon, Butterfly stroke and Diving Starts in Swimming, High Jump, Alpine Skiing, Snowboarding, Squat Lift, and Football Team Competition (Soccer).

PHYSICAL EXAMINATION

Blood Pressure: ____/____ **Weight:** ____ **Height:** ____

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Other: _____

I have reviewed the above health information and have performed the above examination on this athlete within the past 6 months and certify that the athlete can participate in Special Olympics.

SPORTS RESTRICTIONS: _____

EXAMINERS SIGNATURE: _____ **DATE:** ____/____/____
MONTH DAY YEAR

Print Examiners Name: _____ **Certification:** MD DO DC PA ARNP
 Address: _____
 City: _____ State: _____ Zip: _____ Phone: _____

SOWY use only

New Athlete
 Recorded in GMS (date: _____)
 Initial: _____

IMPORTANT: The following should keep copies of this form: 1) The State Office
 2) The Local Program 3) The Head Coach 4) Athlete's Parent/Legal Guardian
 All coaches will be responsible for having up-to-date athlete medical forms in their possession at training and competition events and during transportation and travel.