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# APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS WYOMING

(For individuals with intellectual disabilities)

*This form must be updated every three years*

## DEMOGRAPHICS

### ATHLETE INFORMATION

Local Program: \_\_\_\_\_ Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Gender:  Male  Female  
 Athlete Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
LAST FIRST MI  
 Address: \_\_\_\_\_  
STREET CITY STATE ZIP CODE

### PARENT/GUARDIAN INFORMATION

Name: \_\_\_\_\_  Please add us to the SOWY Newsletter mailing list  
 Address (if different): \_\_\_\_\_  
STREET CITY STATE ZIP CODE  
 Work Phone: (\_\_\_\_) \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ e-mail: \_\_\_\_\_  
 Emergency Contact (if other than parent/guardian): \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
 Health/Accident Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

## HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER

<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Heart Disease/Heart Defect/High Blood Pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Allergies: _____
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Medicines: _____
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Seizures/Epilepsy/Fainting Spells	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Food: _____
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Insect Stings/Bites: _____
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Concussion or Serious Head Injury	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Special Diet
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Major Surgery or Serious Illness	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Asthma (exercise induced wheezing)
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Heat Stroke/Exhaustion	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Tobacco Use
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Blindness/Impaired Vision	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Tendency to bleed easily
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Contact Lenses/Glasses	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Emotional/Psychiatric/Behavioral
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Hearing Loss/Hearing Aid	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Sickle Cell Trait or Disease
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Impaired Motor ability	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Uses a wheelchair
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Bone or Joint Problem	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Dentures/False Teeth
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Parent/Sibling (under 40) died of Heart Disease	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Immunizations Up To Date
Date of most recent tetanus immunization: ____/____/____		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Other: _____

**Medications:** \_\_\_\_\_ (Use separate sheet for additional space.)  
 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 PARENT/GUARDIAN/ADULT ATHLETE:** \_\_\_\_\_ **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. 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).

**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)

## PHYSICAL EXAMINATION

**Blood Pressure:** \_\_\_\_ / \_\_\_\_ **Weight:** \_\_\_\_ **Height:** \_\_\_\_

Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Vision	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Extremities	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Gastrointestinal System	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Cranial Nerves
<input type="checkbox"/>	<input type="checkbox"/>	Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular System	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary System	<input type="checkbox"/>	<input type="checkbox"/>	Coordination
<input type="checkbox"/>	<input type="checkbox"/>	Oral Cavity	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory System	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	Reflexes
<input type="checkbox"/>	<input type="checkbox"/>	Neck									

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.

RESTRICTIONS: \_\_\_\_\_  
**EXAMINERS SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MONTH DAY YEAR

Print Examiners Name & Title: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_