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# 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

<b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>	<b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>	<b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
<input type="checkbox"/> Heart Problem/High Blood Pressure	<input type="checkbox"/> Blindness/Impaired Vision	<input type="checkbox"/> Emotional/Psychiatric/Behavioral
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Contact Lenses/Glasses	<input type="checkbox"/> Sickle Cell Trait or Disease
<input type="checkbox"/> Seizures/Epilepsy/Fainting Spells	<input type="checkbox"/> Hearing Loss/Hearing Aid	<input type="checkbox"/> Uses a Wheelchair
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Bone or Joint Problem	<input type="checkbox"/> Immunizations Up to Date
<input type="checkbox"/> Concussion or Serious Head Injury	<input type="checkbox"/> Asthma (exercise induced wheezing)	<input type="checkbox"/> Tendency to Bleed Easily
<input type="checkbox"/> Major Surgery or Serious Illness _____	<input type="checkbox"/> Tobacco Use	<input type="checkbox"/> Heat Stroke/Exhaustion

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:** \_\_\_\_\_

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

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.