

MEDICAL RELEASE FORM

Artzonu	SOAZ USE ONLY:
Delegation/Program Name:	□ New Athlete□ Recorded in GMS
Area #: Program #:	□ Initial
Please print clearly and complete all sections in their entirety	

Please print clearly and complete **all** sections in their entirety

This application expires three (3) years from the date of physical exam

	SECTION A: DEN	MOGRAPHICS					
Athlete Nam	2:	Date of Birth Male Female (month/date/year): / /					
Athlete Addr	ess:	_ Athlete Age:					
Apt#		Athlete Home Phone: ()					
City:	State: Zip:	Parent Primary Phone: ()					
Parent/ Guardian Na	ne:	Athlete E-mail:					
Parent/Guard	lian Address nan athlete):	Devent Consil.					
(ii dinerent t	ian atmete):	Parent E-mail: Emergency					
City:	State: Zip:	Contact Phone: ()					
Health/Accid	ent Insurance Company:	Emergency Contact (if other than Parent/Guardian):					
Policy#:		Primary Language:					
Ethnic Backg record keepi	round (optional) Solely to help us comply with government \log , reporting, and other legal requirements, please check \log to the right \rightarrow	□American Indian or Alaska Native □Asian □Black or African American □Native Hawaiian or Other Pacific Islander □Latino/Hispanic □White					
	SECTION B: HEALTH HISTORY (MAY BE COMPLET PLEASE INDICATE "YES" O						
Yes No	PLEASE INDICATE "YES" O						
Yes No	PLEASE INDICATE "YES" O	OR "NO" FOR ALL AREAS					
	PLEASE INDICATE "YES" O	Yes No					
	PLEASE INDICATE "YES" O Allergies to Medicine:	Yes No Requires Constant Supervision Hearing Loss/Hearing Aid					
	Allergies to Food: PLEASE INDICATE "YES" O Allergies to Medicine:	Yes No Requires Constant Supervision Hearing Loss/Hearing Aid					
	Allergies to Medicine: Allergies to Food: Allergies to Stings/Bites:	Yes No Requires Constant Supervision Hearing Loss/Hearing Aid Heart Disease/Heart Defect/High Blood Pressure					
	Allergies to Medicine: Allergies to Food: Allergies to Stings/Bites: Allergies to Other:	Yes No Requires Constant Supervision Hearing Loss/Hearing Aid Heart Disease/Heart Defect/High Blood Pressure Heat Stroke/Exhaustion					
	Allergies to Medicine: Allergies to Food: Allergies to Stings/Bites: Allergies to Other: Special Diet:	Yes No Requires Constant Supervision Hearing Loss/Hearing Aid Heart Disease/Heart Defect/High Blood Pressure Heat Stroke/Exhaustion Immunizations up-to-date					
	Allergies to Medicine: Allergies to Food: Allergies to Stings/Bites: Allergies to Other: Special Diet: Blindness/Visual Problems (other than corrective lenses)	Yes No Requires Constant Supervision Hearing Loss/Hearing Aid Heart Disease/Heart Defect/High Blood Pressure Heat Stroke/Exhaustion Immunizations up-to-date Major Surgery or Serious Illness					
	Allergies to Medicine: Allergies to Food: Allergies to Stings/Bites: Allergies to Other: Special Diet: Blindness/Visual Problems (other than corrective lenses) Bone or Joint Problem Chest Pain Concussion or Serious Head Injury	Yes No Requires Constant Supervision Hearing Loss/Hearing Aid Heart Disease/Heart Defect/High Blood Pressure Heat Stroke/Exhaustion Immunizations up-to-date Major Surgery or Serious Illness Autism					
	Allergies to Medicine: Allergies to Food: Allergies to Stings/Bites: Allergies to Other: Special Diet: Blindness/Visual Problems (other than corrective lenses) Bone or Joint Problem Chest Pain Concussion or Serious Head Injury Contact Lenses/Glasses	Yes No Requires Constant Supervision Hearing Loss/Hearing Aid Heart Disease/Heart Defect/High Blood Pressure Heat Stroke/Exhaustion Immunizations up-to-date Major Surgery or Serious Illness Autism Seizures/Epilepsy/Fainting Spells Sickle Cell Trait or Disease Asthma					
	Allergies to Medicine: Allergies to Food: Allergies to Stings/Bites: Allergies to Other: Special Diet: Blindness/Visual Problems (other than corrective lenses) Bone or Joint Problem Chest Pain Concussion or Serious Head Injury Contact Lenses/Glasses Diabetes	Yes No Requires Constant Supervision Hearing Loss/Hearing Aid Heart Disease/Heart Defect/High Blood Pressure Heat Stroke/Exhaustion Immunizations up-to-date Major Surgery or Serious Illness Autism Seizures/Epilepsy/Fainting Spells Sickle Cell Trait or Disease Asthma Uses Tobacco					
	Allergies to Medicine: Allergies to Food: Allergies to Stings/Bites: Allergies to Other: Special Diet: Blindness/Visual Problems (other than corrective lenses) Bone or Joint Problem Chest Pain Concussion or Serious Head Injury Contact Lenses/Glasses Diabetes Shunts	Yes No Requires Constant Supervision Hearing Loss/Hearing Aid Heart Disease/Heart Defect/High Blood Pressure Heat Stroke/Exhaustion Immunizations up-to-date Major Surgery or Serious Illness Autism Seizures/Epilepsy/Fainting Spells Sickle Cell Trait or Disease Asthma Uses Tobacco Uses Wheelchair					
	Allergies to Medicine: Allergies to Food: Allergies to Stings/Bites: Allergies to Other: Special Diet: Blindness/Visual Problems (other than corrective lenses) Bone or Joint Problem Chest Pain Concussion or Serious Head Injury Contact Lenses/Glasses Diabetes	Yes No Requires Constant Supervision Hearing Loss/Hearing Aid Heart Disease/Heart Defect/High Blood Pressure Heat Stroke/Exhaustion Immunizations up-to-date Major Surgery or Serious Illness Autism Seizures/Epilepsy/Fainting Spells Sickle Cell Trait or Disease Asthma Uses Tobacco					
	Allergies to Medicine: Allergies to Food: Allergies to Stings/Bites: Allergies to Other: Special Diet: Blindness/Visual Problems (other than corrective lenses) Bone or Joint Problem Chest Pain Concussion or Serious Head Injury Contact Lenses/Glasses Diabetes Shunts	Yes No Requires Constant Supervision Hearing Loss/Hearing Aid Heart Disease/Heart Defect/High Blood Pressure Heat Stroke/Exhaustion Immunizations up-to-date Major Surgery or Serious Illness Autism Seizures/Epilepsy/Fainting Spells Sickle Cell Trait or Disease Asthma Uses Tobacco Uses Wheelchair					

Jale of Host	recent tetanus immuniz	zation:	//_						
is the athlete	taking any prescription	n medications	s? Yes 🗌 No	☐ If yes,	please list all medication	ns below.			
**All changes	s in medication should b	e submitted	to Special Ol	lympics Ar	zona. For more space, p	lease attach	ո addition	al paper.	
_			Date	Times	1			Date	Times
M	ledication Name	Dosage	Prescribed	per day	Medication Nam	ne	Dosage	Prescribed	per day
1)				<u> </u>	4)				
2)					5)				
3)				<u> </u>	6)				
SIGNATURE	OF PERSON COMPLE	TING THIS	FORM (PA	RENT/CA	REGIVER/ADULT ATH	ILETE):			
			,	,					
Signature	 e		- <i></i> ′	/			ed Name		
	SECTION C: ATLA	NTO-AXIAL	INSTABILIT	TY ASSES	SMENT FOR ATHLETE	S WITH DO	OWN SYN	NDROME	
Does the a	thlete have Down Sv	ndrome? Y	es □ No □ I	f ves, voi	ı must complete the a	rea below	<i>i</i> .		
	_				-			C 2 semplete	
equestrian sp	ports, gymnastics, diving	, pentathlon,			is required and the <u>Spe</u> ing starts in swimming, h				
	team competition (socce		-				'	.	C
PLEASE CH	ECK THE FOLLOWING	:							
Yes No									
	Does the athlete participate in a restricted sport or event? If yes or unknown, an x-ray for atlanto-axial instability must be done.								
	Does the athlete partici	pate in a rest	ricted sport o	r event? If	yes or unknown, an x-ray	for atlanto-	axial insta	bility must be	done.
	•		-		yes or unknown, an x-ray Please provide X-Ra			-	done.
	Has an x-ray evaluation	n for atlanto-a	axial instability	been done		y Date:			done.
	Has an x-ray evaluation	n for atlanto-a	axial instability	been done	e? Please provide X-Ra	y Date:			done.
	Has an x-ray evaluation If yes, was the x-ray po	n for atlanto-a	axial instability anto-axial insta	/ been done ability? Pos	e? Please provide X-Ra	ny Date:	erval is 5m	mm or more.	
	Has an x-ray evaluation If yes, was the x-ray posseries SECTION D: PHYSICA Sure: /	n for atlanto-a positive for atla	axial instability anto-axial insta ATION (MUS Weight:	been done ability? Pos	e? Please provide X-Ra	nto-dens inte	erval is 5m	nm or more. FESSIONAL)	
Blood Press	Has an x-ray evaluation If yes, was the x-ray possible SECTION D: PHYSICA Sure: / Abnormal	n for atlanto-a positive for atla	axial instability anto-axial insta ATION (MUS Weight: Normal Ab	been done ability? Pos	e? Please provide X-Ra itive indication is the atlar MPLETED BY A LICENS	nto-dens inte	erval is 5m	mm or more. FESSIONAL))
Blood Press Normal	Has an x-ray evaluation If yes, was the x-ray possible of the control of the cont	n for atlanto-a positive for atla	ATION (MUS Weight: Normal Ab	been done ability? Pos TBE COM bnormal Ca	e? Please provide X-Ra itive indication is the atlar MPLETED BY A LICENS ardiovascular system	nto-dens inte	Abnorm	FESSIONAL) Tal Cranial ner	ves
Blood Press Normal	Has an x-ray evaluation If yes, was the x-ray possible SECTION D: PHYSICA Sure: / Abnormal	n for atlanto-a positive for atla	ATION (MUS Weight: Normal Ab	been done ability? Pos T BE COM Conormal Ca Re	e? Please provide X-Ra itive indication is the atlar MPLETED BY A LICENS ardiovascular system espiratory system	nto-dens inte	EAL PROI	FESSIONAL) nal Cranial ner Coordinatio	ves
Blood Press Normal	Has an x-ray evaluation If yes, was the x-ray po SECTION D: PHYSICA SURE: / Abnormal Vision Hearing Oral cavity	n for atlanto-a positive for atla	ATION (MUS Weight: Normal Ab	been done ability? Pos T BE COM conormal Re Garage	e? Please provide X-Ra itive indication is the atlar MPLETED BY A LICENS ardiovascular system espiratory system astrointestinal system	nto-dens inte	Abnorm	FESSIONAL) Tal Cranial ner	ves
Blood Press Normal	Has an x-ray evaluation If yes, was the x-ray possible SECTION D: PHYSICA Sure: / Abnormal	n for atlanto-a	axial instability anto-axial insta ATION (MUS Weight: Normal Ab	been done ability? Pos TBE COM Donormal Re Ga Ga Ga	e? Please provide X-Ra itive indication is the atlar MPLETED BY A LICENS ardiovascular system espiratory system	nto-dens inte	EAL PROI	FESSIONAL) nal Cranial ner Coordinatio	ves
Blood Press Normal	Has an x-ray evaluation If yes, was the x-ray po SECTION D: PHYSICA Sure: / Abnormal Vision Hearing Oral cavity Neck	n for atlanto-a	ATION (MUS Weight: Normal Ab	been done ability? Pos TBE COM Donormal Re Ga Ga Ga	e? Please provide X-Ra itive indication is the atlar MPLETED BY A LICENS ardiovascular system espiratory system estrointestinal system enitourinary system	nto-dens inte	EAL PROI	FESSIONAL) nal Cranial ner Coordinatio	ves
Blood Press Normal	Has an x-ray evaluation If yes, was the x-ray possible SECTION D: PHYSICA Sure: / Abnormal Vision Hearing Oral cavity Neck Extremities	n for atlanto-a	ATION (MUS Weight: Normal Ab	been done ability? Pos TBE COM Donormal Re Ga Ga Ga	e? Please provide X-Ra itive indication is the atlar MPLETED BY A LICENS ardiovascular system espiratory system estrointestinal system enitourinary system	nto-dens inte	EAL PROI	FESSIONAL) nal Cranial ner Coordinatio	ves
Blood Press Normal Other: Primary MR	Has an x-ray evaluation If yes, was the x-ray possible SECTION D: PHYSICA SURE: / Abnormal Vision Hearing Oral cavity Neck Extremities R Etiology/Category (if	a for atlanto-a positive for atlanto-a AL EXAMINA fractions in the state of the sta	axial instability anto-axial insta ATION (MUS Weight: Normal Ab	been done ability? Pos T BE COM Donormal Re GG GG Sh Dormation an	e? Please provide X-Ra itive indication is the atlar MPLETED BY A LICENS ardiovascular system espiratory system eastrointestinal system enitourinary system and have performed the about	nto-dens inte	Abnorm	FESSIONAL) Tal Cranial ner Coordination Reflexes	ves
Blood Press Normal Other: Primary MR	Has an x-ray evaluation If yes, was the x-ray possible SECTION D: PHYSICA Sure: / Abnormal Vision Hearing Oral cavity Neck Extremities R Etiology/Category (ift No I have revising in the property of the property	a for atlanto-a positive for atlanto-a AL EXAMINA fractions in the state of the sta	axial instability anto-axial insta ATION (MUS Weight: Normal Ab	been done ability? Pos T BE COM Donormal Re GG GG Sh Dormation an	e? Please provide X-Ra itive indication is the atlar MPLETED BY A LICENS ardiovascular system espiratory system eastrointestinal system enitourinary system kin	nto-dens inte	Abnorm	FESSIONAL) Tal Cranial ner Coordination Reflexes	ves
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Blood Press Normal Other: Primary MR Yes Sport Restrice	Has an x-ray evaluation If yes, was the x-ray possible SECTION D: PHYSICA Sure: / Abnormal Vision Hearing Oral cavity Neck Extremities R Etiology/Category (if No I have revisix (6) more tions:	f known): ewed the about the and certification and certification.	axial instability anto-axial insta ATION (MUS Weight: Normal Ab	been done ability? Pos T BE COM Donormal Re GG GG Sh Dormation an	e? Please provide X-Ra itive indication is the atlar MPLETED BY A LICENS ardiovascular system espiratory system eastrointestinal system enitourinary system and have performed the about	nto-dens inte	Abnorm	FESSIONAL) Tal Cranial ner Coordination Reflexes	ves
Blood Press Normal Other: Primary MR Yes Sport Restrice Examiner's Examiner's	Has an x-ray evaluation If yes, was the x-ray possible SECTION D: PHYSICA Sure: / Abnormal Vision Hearing Oral cavity Neck Extremities R Etiology/Category (if No I have revisix (6) more six (6) more tions: Signature (required Name:	f known): ewed the about the and certification and certification.	axial instability anto-axial insta ATION (MUS Weight: Normal Ab	been done ability? Pos T BE COM Donormal Re GG GG Sh Dormation an	e? Please provide X-Ra itive indication is the atlar MPLETED BY A LICENS ardiovascular system espiratory system eastrointestinal system enitourinary system and have performed the aboraticipate in Special Olymp	nto-dens inte	Abnorm	FESSIONAL) Tal Cranial ner Coordination Reflexes	ves
Blood Press Normal Other: Primary MR Yes Sport Restrice	Has an x-ray evaluation If yes, was the x-ray possible SECTION D: PHYSICA Sure: / Abnormal Vision Hearing Oral cavity Neck Extremities R Etiology/Category (if No I have revisix (6) more six (6) more tions: Signature (required Name:	f known): ewed the about the and certification and certification.	axial instability anto-axial insta ATION (MUS Weight: Normal Ab	been done ability? Pos T BE COM CT BE COM	e? Please provide X-Ra itive indication is the atlar MPLETED BY A LICENS ardiovascular system espiratory system eastrointestinal system enitourinary system and have performed the aboraticipate in Special Olymp	nto-dens inte	Abnorm	FESSIONAL) Tal Cranial ner Coordination Reflexes	ves
Blood Press Normal Other: Primary MR Yes Sport Restrice Examiner's Examiner's	Has an x-ray evaluation If yes, was the x-ray possible SECTION D: PHYSICA Sure: / Abnormal Vision Hearing Oral cavity Neck Extremities R Etiology/Category (if No I have revisix (6) more tions: Signature (required Name: y or stamp	f known): ewed the about the and certification and certification.	ATION (MUS Weight: Normal Ab	been done ability? Pos T BE CON Donormal GG GG GG Sk Dormation an nlete can pa	e? Please provide X-Ra itive indication is the atlar MPLETED BY A LICENS ardiovascular system espiratory system eastrointestinal system enitourinary system and have performed the aboraticipate in Special Olymp	nto-dens inte	Abnorm	FESSIONAL) Tal Cranial ner Coordination Reflexes	ves

^{**}The following should keep copies of this form: 1) The State Office 2) The Delegation/Program
3) The Head Coach 4) Athlete's Parent/Legal Guardian



OFFICIAL SPECIAL OLYMPICS CONSENT FORM

Artzona								
Delegation/Prog	ıram Name:			Area #:	: F	Program #:		
Athlete's Name:	Last:		First:			D.O.B.: _	/	
	RELEASE TO BE COM	PLETED BY PARENT	/GUARD	DIAN OR ADULT ATHLE	TE (OWN G	UARDIAN)		
I, the Parent/Gua	ardian or Adult Athlete s	ubmits this Official Sp	ecial Olyı	mpics Release Form for p	participation	in Special (Olympi	cs.
Olympics activities	varrant that, to the best of es. I also represent that a has certified, based on a pecial Olympics.	icensed physician has	reviewe	d the health information c	contained in	the applica	tion for	•
extension, radica syndrome Adden with Down syndro	if the athlete has Down soll flexion or direct pressure adum Form", available fron ome may participate in equency, snowboarding, squat lit	on the neck or upper the Special Olympics uestrian, gymnastics, j	spine un State O	less the athlete and physiffice. I am aware that the	ician have c x-ray exam	completed the is required	ne offici before	ial "Down any athlete
radio, film, newsp	s has my permission, both papers, magazines and ot ial Olympics and/or applyi	ner media, and in any	form, for	the purpose of advertising				
parent/guardian of	ete's participation in Speci or adult athlete) am not ab res necessary to protect th	le to give consent or n	nake arra	ingements for that treatme	ent, I author	ize Special		
screening assess health promotion may decide not to should seek inde responsible for the	signing below, that I consessments of health status an areas. I understand there o participate. Provisions opendent medical advice an health of the athlete. I ummunicate overall health	d health care needs in is no obligation for the f these health services nd assistance irrespect nderstand that information	the area athlete are not it tive of thation gath	is of vision, oral health, he to participate in the Healt intended as a substitute for e provisions of these serv hered as part of the scree	earing, phys thy Athletes for regular cavices and the ening proces	sical therapy Program ar are. I also u at Special 0 s may be u	/, and a nd that ndersta Dlympic	a variety of the athlete and that I cs is not
To be comp	leted by Adult Athlete	(own Guardian)	OR	To be comp	leted by P	arent/Gua	ırdian	
the provisions that I have rea the Code of C signing this pathis release. Signature	chlete, have read this form of the release that I am s ad and agree to the Athlete onduct Compliance Policy aper, I am saying that I agr	gning. I acknowledge e Code of Conduct and . I understand that by ee to the provisions of	f -	I, the Parent/Guardian permission for this athle games, training, recrea and Healthy Athletes pragree to the Athlete Co Compliance Policy. By provisions of this releast Signature	ete to partic ation prograr rogram. I ac ode of Condo signing, I ar se.	ipate in Spens, physica in section when the work and the maying the	ecial Ol I activit I have Code c at I agr	lympics ty programs read and of Conduct ree to the
whose signatu	y that I have reviewed this ure appears above. I am s e athlete understands this erms.	atisfied, based on that		Jule				
Signature			_					
Print Name			_					
Date:/_	/							
THIS F	ORM MUST BE COMPLETE	D LEGIBLY, SIGNED, A	ND DATE	D TO BE CONSIDERED VA	ALID FOR TH	REE (3) YEA	ARS	