ATHLETE RELEASE FORM

I want to take part in Special Olympics and agree to the following:

1. **Agreement to Participate**: I am able to take part in Special Olympics. Know there are risks of injury.

2. **Photo Release**: Special Olympics organizations may use my picture, video, name, voice, and words to promote Special Olympics programs.

3. **Overnight Stay**: For some events, I may stay in a hotel or someone's home. If I have questions, I will ask.

4. **Emergency Care**: If I am unable to make medical decisions, I authorize my guardian to make medical decisions in an emergency. I authorize Special Olympics to seek medical care on my behalf, unless I check one of the boxes below:
   - I authorize the exclusion of medical care.
   - If I have a religious or other objection to receiving medical treatment, I authorize Special Olympics to provide medical care.
   - I do not consent to blood transfusions.

5. **Health Programs**: If I take part in a health program, I consent to health activities, exams, and treatment. This should not replace regular health care. I can say no to treatment or anything else anytime.

6. **Personal Information**: I understand my information may be used and shared. With my information, I can ask to see and change my information.

7. **Concussions**: I understand the potential risk of concussions and may have a suspected concussion. If I have a suspected concussion, I may have to get medical care if necessary and may be removed for a period of 7 days or more. You must get permission from a doctor before restarting sports.

**ATHLETE NAME:**

**SIGNATURE:**

**DATE:**

**PARENT/GUARDIAN NAME:**

**SIGNATURE:**

**DATE:**

**RELATIONSHIP:**

**DATE:**

**Parent/Guardian Name:**

- I am a parent or guardian of the athlete. I read and understand this form and have explained its contents to the athlete as appropriate. By signing, I agree to this form.
<table>
<thead>
<tr>
<th>Region/Area:</th>
<th>Delegation/Team:</th>
<th>Athlete Information</th>
<th>Athlete Medical Form - Health History</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name:</td>
<td>Last Name:</td>
<td>Date of Birth:</td>
<td>Does the athlete have any chronic or acute infection?</td>
</tr>
<tr>
<td>Male/Female</td>
<td>Address (Street):</td>
<td>City, State, Zip:</td>
<td>Does the athlete currently have any chronic or acute infection?</td>
</tr>
<tr>
<td>Phone:</td>
<td>Email:</td>
<td>Cell:</td>
<td>Does the athlete ever had an abnormal Electrocardiogram (EKG) or Electroencephalogram (EEG)? Yes, had abnormal EKG Yes, had abnormal EEG</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Does the athlete ever had a heart problem before age 50? Yes, had heart problem before age 50</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Has any family member or relative died while exercising?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Medical Form for US Programs - Updated June 2016</td>
</tr>
</tbody>
</table>

Special Olympics Medical Form 11 of 4
### Athlete Medical Form – HEALTH HISTORY

(pages 1 & 2 to be completed by athlete or parent/guardian/caregiver)

**Athlete's Name:**

**Athlete's Age:**

**Date of Birth:**

**Height:**

**Weight:**

**Blood Type:**

**Allergies:**

**Previous Injuries:**

**Medications:**

**Vision Impairment:**

**Hearing Impairment:**

**Speech Impairment:**

**Learning Disability:**

**Multiple Disabilities:**

**Dislocated Joints:**

**Broken Bones:**

**Sickle Cell Disease:**

**Sickle Cell Trait:**

**Seizures:**

**High Blood Pressure:**

**High Cholesterol:**

**Diabetes:**

**Gallbladder Disease:**

**Renal Disease:**

**Hepatitis:**

**Urinary Incontinence:**

**Urinary Tract Infection:**

**Arthritis:**

**Heel Injuries:**

**Cervical Spondylosis:**

**Back Pain:**

**Shoulder Pain:**

**Elbow Pain:**

**Wrist Pain:**

**Hip Pain:**

**Knee Pain:**

**Foot Pain:**

**Any Other Musculoskeletal Conditions:**

**Any Other Medical Conditions:**

**Any Other Mental Health Concerns:**

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**Describe any past broken bones or dislocated joints (if yes is checked for either of these fields alone):**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Describe any past seizures (if yes is checked):**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

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**Describe any past aggressive behavior during the past year (if yes is checked):**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Describe any additional mental health concerns:**

<table>
<thead>
<tr>
<th>Mental Health Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

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**List any other ongoing or past medical conditions:**

<table>
<thead>
<tr>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

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**List any other medications, vitamins, or dietary supplements being used:**

<table>
<thead>
<tr>
<th>Medication/Vitamin/Supplement</th>
<th>Dose/Usage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Is the athlete able to administer his or her own medications?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Relationship to Athlete:**

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

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**Special Olympics Medical Form – 12 of 4**

**Medical Form for US Programs – Updated June 2016**
Athlete's Name:

Medical Physical Information (to be completed by examiner only)

Vision
- Right Vision: 20/20 or better
- Left Vision: 20/20 or better

Blood Pressure
- Right: [Value]
- Left: [Value]

Temperature
- Oral: [Value]
- Rectal: [Value]

Pulse
- Rate: [Value]

Bowel Sounds
- Normal

Hepatomegaly
- Absent

Abdominal Tenderness
- Absent

Blood Smears
- No

Hyporeflexia
- Absent

Left lower extremity reflex
- Normal

Hyporeflexia
- Absent

Left upper extremity reflex
- Normal

Hyporeflexia
- Absent

Abnormal Gait
- Absent

Physician Does Not Feel the Need for Further Medical Evaluation
- Yes

Additional Medical Information
- Other

Recommended Follow-up
- Follow up with a primary care physician
- Follow up with a dermatologist
- Other

Athlete's Health History

- Hypertension
- Diabetes
- Asthma
- Other

Additional Medical Information
- Other

Recommended Follow-up
- Follow up with a primary care physician
- Follow up with a neurologist
- Other

Post-surgical Care
- Other

Additional Medical Information
- Other

Recommended Follow-up
- Follow up with a physical therapist
- Other

Licensing Information
- Name:
- Email:
- Phone:
- Date of Exam:
- Medical Form for US Programs - updated June 2016

License:
- [Signature]
This section to be completed by Special Olympics staff only, if applicable.

Young Athlete □  Unified Partner □  Young Athlete Participant □  Unified Partner Participant □  Unified Partner Group Participant □  Unified Partner Group Participant Group Participant □

Date

Examiner’s Signature

License

Examiner Phone

Examiner Email

Additional Examiner Notes/Restrictions:

Yes □  No □  Yes, but with restrictions (list below) □

In my professional opinion, this athlete may participate in Special Olympics sports (indicate restrictions or limitations below):

Please describe why athlete is able to compete in Special Olympics sports:

Specialty:

Examiner’s Name:

The specialist indicated follow-up is required. Athlete should bring the previously completed pages to the appointment with this page only needs to be completed and signed if the physician on page three does not clear the athlete and

Athlete’s Name: