



ATHLETE APPLICATION FOR PARTICIPATION – SPECIAL OLYMPICS NEBRASKA

11011 Q Street, Suite 104 C • Omaha NE 68137 • 402.331.5545 or 800.247.0105 • Fax: 402-331-5964

SECTION A – DEMOGRAPHICS

Program/Team _____ or School _____ Grade _____

Athlete Information:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Gender: Male Female Date of Birth: _____
Employer: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email Address: _____

Parent/Guardian Information:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Employer: _____
Home Phone: _____
Work Phone: _____
Cell Phone #1: _____
Cell Phone #2: _____
Email Address #1: _____
Email Address #2: _____

Special Olympics Nebraska (SONE) receives inquiries from various granting organizations and agencies regarding racial/ethnic composition. Kindly mark the appropriate box:

Race/Ethnicity: Caucasian African American Native American Asian Hispanic Other

SECTION B - HEALTH INSURANCE & EMERGENCY CONTACT INFORMATION

Person to be contacted in case of emergency: _____ Phone Number: _____

Medical Insurance Company: _____ Policy Number: _____

SECTION C - HEALTH HISTORY

- | | <u>Circle One</u> | | <u>Circle One</u> |
|---|-------------------|---|-------------------|
| 1. Heart Disease/Heart Defect/High Blood Pressure | Yes No | 13. Allergy: _____ | Yes No |
| 2. Chest pain | Yes No | 14. Down Syndrome | Yes No |
| 3. Seizures/epilepsy/Fainting Spells | Yes No | 15. X-ray done to check instability? | Yes No |
| 4. Diabetes | Yes No | 16. Was X-ray positive for Instability? | Yes No |
| 5. Concussion or Serious Head Injury | Yes No | 17. Special Diet | Yes No |
| 6. Major Surgery or Serious Illness | Yes No | 18. Immunization up to date. | Yes No |
| 7. Heat stroke/Heat Exhaustion | Yes No | 19. Tobacco Use | Yes No |
| 8. Blindness/Visual Problem | Yes No | 20. Uses Wheelchair/Walker (Circle One) | Yes No |
| 9. Wears Contact Lenses/Glasses | Yes No | 21. Emotional/Psychiatric/Behavioral | Yes No |
| 10. Hearing Loss/Hearing Aid/Non-Verbal | Yes No | 22. Sickle Cell Trait or Disease | Yes No |
| 11. Bone or Joint Problems | Yes No | 23. Easy Bleeding | Yes No |
| 12. Asthma | Yes No | 24. Other: _____ | |

Date of last Tetanus immunization: _____

Signature of parent/caregiver/adult athlete: _____ Date: _____

Please complete reverse side for medical information

SECTION E - PHYSICAL EXAMINATION – TO BE COMPLETED BY LICENSED PHYSICIAN

Blood pressure: ____/____ Weight: _____ Height: _____

Normal/Abnormal		Normal/Abnormal		Normal/Abnormal				
____	____	Vision	____	____	Cardiovascular system	____	____	Cranial nerves
____	____	Hearing	____	____	Respiratory system	____	____	Coordination
____	____	Oral cavity	____	____	Gastrointestinal system	____	____	Reflexes
____	____	Neck	____	____	Genitourinary system	____	____	
____	____	Extremities	____	____	Skin			

Other: _____

Primary MR Etiology/Category (If known.): _____

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.

RESTRICTION: _____

EXAMINER'S SIGNATURE: _____ **DATE:** _____

EXAMINER'S NAME: _____

Address: _____ **Phone:** _____

SECTION F - RELEASE FORM

I, undersigned, represent and warrant that, to the best of my knowledge and belief, I am/my child is/my ward is physically and mentally able to participate in Special Olympics Nebraska. With my approval, a licensed physician is authorized to review the health information set forth in this application, and administer a medical examination so as to certify that there is no medical evidence which would preclude me/my child's/my ward's participation. I understand that if I/my child/my ward has Down Syndrome, I/he/she cannot participate in sports or events which by their nature result in hyper-extension, radical flexion or direct pressure on the neck or upper spine, unless a full radiological examination establishes the absence of Atlanto-axial instability. I am aware that the sports and events for which this radiological examination is required are judo, equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, squat lift, snowboarding and soccer team competition.

Special Olympics Nebraska has my permission to use my/my child's/my ward's likeness, name, voice and words in television, radio, film, newspaper, magazines and any other media, and in any form, for the purpose of advertising or communicating the purpose and activities of Special Olympics Nebraska and/or applying funds to support those purposes and activities.

If a medical emergency should arise during my/my child's/my ward's participation in any Special Olympics Nebraska activities and I am not able to give my consent, for whatever reason, I authorize Special Olympics Nebraska to take whatever measures are necessary and which it deems advisable, to protect my/my child's/ my ward's health and well-being, including hospitalization

I have read and fully understand the provisions of the above release and have explained the provisions to my child/ward. I understand that through my signature on this release form, I am agreeing to the above provisions on my own behalf or on the behalf of my child/ward, and hereby give my permission for my child/ward to participate in Special Olympics Nebraska games, recreation programs and physical activities.

Clearly Print Athletes, Name: _____

Signature of Parent/Caregiver/Adult Athlete: _____