

Medical / Release Form

Each participant **MUST** have a current medical / release form on file with Special Olympics Kansas, 5280 Foxridge Drive, Mission, Kansas 66202 and in the possession of the coach prior to participating in any event/training/competition.

DEMOGRAPHICS			
TEAM NAME: <u>Air Capital Flyers</u>	NUMBER: <u>670</u>		
Athlete's Name _____	<input type="checkbox"/> Male	Date of Birth (month/day/year) _____	
	<input type="checkbox"/> Female	_____ / _____ / _____	
Athlete's Address _____	Athlete Home Phone # _____	_____ () _____	
City: _____ State: _____ Zip: _____	Parent Email Address _____	_____	
Parent/Guardian's Name _____	Parent Primary Phone # _____	_____ () _____	
Parent/Guardian's Address (if different than athlete) _____	Parent Cell/Alternate Phone# _____	_____ () _____	
	Parent Employer _____	_____	
Emergency Contact (if other than parent/guardian) _____	Emergency Phone #/Cell _____	_____ () _____	
Health/Accident Insurance Company _____	Policy # _____	_____	

PARTICIPATION AND CONSENT TO TREATMENT: I hereby give permission for the participant named above to participate. To the best of my knowledge, the athlete is physically and mentally able to participate and full disclosure of the participant's medical history has been made to the physician whose signature appears below.

I acknowledge that the participant will be using facilities at his own risk and said parent/guardian, on his behalf, hereby releases, discharges and indemnifies from all liability for alleged injury to person or damage to property of himself and applicant.

I hereby irrevocably grant permission to record the above participant's likeness and/or voice for use by television, films, radio or printed media to further the aims of Special Olympics.

If I am not personally present at activities, in case of necessity, you are authorized, on my behalf and at my account, to take such measures and arrange for such medical and hospital treatment as you may deem advisable for the health and well-being of the participant.

HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER							
Yes	No						
<input type="checkbox"/>	<input type="checkbox"/>	*Heart disease / heart defect / high blood pressure	<input type="checkbox"/> <input type="checkbox"/> Allergy: _____				
<input type="checkbox"/>	<input type="checkbox"/>	*Chest pain	<input type="checkbox"/> <input type="checkbox"/> Medicines: _____				
<input type="checkbox"/>	<input type="checkbox"/>	*Seizures / epilepsy/fainting spells	<input type="checkbox"/> <input type="checkbox"/> Food: _____				
<input type="checkbox"/>	<input type="checkbox"/>	*Diabetes	<input type="checkbox"/> <input type="checkbox"/> Insect stings/bites: _____				
<input type="checkbox"/>	<input type="checkbox"/>	*Concussion or serious head injury	<input type="checkbox"/> <input type="checkbox"/> Special diet				
<input type="checkbox"/>	<input type="checkbox"/>	*Major surgery or serious illness	<input type="checkbox"/> <input type="checkbox"/> Tobacco use				
<input type="checkbox"/>	<input type="checkbox"/>	*Blindness / visual problem	<input type="checkbox"/> <input type="checkbox"/> Easy bleeding				
<input type="checkbox"/>	<input type="checkbox"/>	*Asthma	<input type="checkbox"/> <input type="checkbox"/> Emotional / psychiatric / behavioral				
<input type="checkbox"/>	<input type="checkbox"/>	Heat stroke / exhaustion	<input type="checkbox"/> <input type="checkbox"/> Sickle cell trait or disease				
<input type="checkbox"/>	<input type="checkbox"/>	Contact lenses / glasses	<input type="checkbox"/> <input type="checkbox"/> Immunizations up to date				
<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss / hearing aid	<input type="checkbox"/> <input type="checkbox"/> Wheelchair				
<input type="checkbox"/>	<input type="checkbox"/>	Bone or joint problem	<input type="checkbox"/> <input type="checkbox"/> Other _____				
(Use additional space, use back of form)							
Date of most recent tetanus immunization _____ / _____ / _____							
(*) Requires physical examination _____							
Medications:							
Please print medication name, amount, date prescribed and number of times per day medication is given.							
Medication Name	Dosage	Date Prescribed	Times per day	Medication Name	Dosage	Date Prescribed	Times per day

NOTE: If there is any significant change in the athlete's health, the athlete's condition **should** be reviewed by a physician before further participation.

PARENT / GUARDIAN / ADULT PARTICIPANT SIGNATURE _____

DOWN SYNDROME: <input type="checkbox"/> YES <input type="checkbox"/> NO	CHECK ONE: ATLANTO-AXIAL <input type="checkbox"/> NEG. <input type="checkbox"/> POS.
<p>NOTE: If the athlete has Down syndrome, requires that the athlete have a full radiological examination establishing the degree, if any, of Atlanto-Axial instability before he / she may participate in any sport or event. Down syndrome forms are available from office.</p>	

MEDICAL CERTIFICATION
 A physical examination can only be conducted by a Medical Doctor (MD), Doctor of Osteopathy (DO), Doctor of Chiropractic (DC), Physician's Assistant, or an Advanced Registered Nurse Practitioner (ARNP).

PHYSICAL EXAMINATION					
Blood pressure: _____ / _____		Weight: _____		Height: _____	
Normal/Abnormal		Normal/Abnormal		Normal/Abnormal	
<input type="checkbox"/> <input type="checkbox"/>	Vision	<input type="checkbox"/> <input type="checkbox"/>	Cardiovascular system	<input type="checkbox"/> <input type="checkbox"/>	Cranial nerves
<input type="checkbox"/> <input type="checkbox"/>	Hearing	<input type="checkbox"/> <input type="checkbox"/>	Respiratory system	<input type="checkbox"/> <input type="checkbox"/>	Coordination
<input type="checkbox"/> <input type="checkbox"/>	Oral cavity	<input type="checkbox"/> <input type="checkbox"/>	Gastrointestinal system	<input type="checkbox"/> <input type="checkbox"/>	Reflexes
<input type="checkbox"/> <input type="checkbox"/>	Neck	<input type="checkbox"/> <input type="checkbox"/>	Genitourinary system		
<input type="checkbox"/> <input type="checkbox"/>	Extremities	<input type="checkbox"/> <input type="checkbox"/>	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.					
RESTRICTIONS: _____					
EXAMINER'S SIGNATURE: _____			DATE: _____ / _____ / _____		
EXAMINER'S NAME: _____					
ADDRESS: _____					
PHONE: () _____					