

SPECIAL OLYMPICS IOWA PHYSICAL & CONSENT FORM

PLEASE PRINT LEGIBLY

Athlete Name _____ Delegation (School/Facility) _____
Birthdate _____ Gender _____ Parent/Guardian (Circle One) _____
Athlete Phone (_____) _____ Parent/Guardian Phone (_____) _____
Athlete Address _____ Parent Address _____
City _____ State _____ Zip _____ City _____ State _____ Zip _____

HEALTH INSURANCE & EMERGENCY INFORMATION

Emergency Contact _____ Emergency Contact Phone (_____) _____
Medical Insurance _____ Policy Number _____

MEDICAL CLEARANCE

Does athlete have Down Syndrome? YES NO If yes, have x-rays of the C1-C2 vertebrae been taken and examined? YES NO

Date of x-ray _____ Atlantoaxial Instability: Positive AA Negative AA

	YES	NO		YES	NO	Blood Pressure _____	Height _____	Weight _____
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Blind	<input type="checkbox"/>	<input type="checkbox"/>	Date of last Tetanus shot _____	Allergies _____	
Epileptic/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Deaf	<input type="checkbox"/>	<input type="checkbox"/>	Other Conditions _____		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>			
Use Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>			

Current Medication (List)

Dosage

Current Medication (List)

Dosage

I have examined the above-named Athlete and, in my opinion, there is no mental or physical reason why he or she should not participate in Special Olympics sports training and competition. Further information will be forwarded if required. Current medication, if any, is specified with dosage on this application.

Sports athlete is **NOT** allowed to participate in: _____

Practitioner's Printed Name _____ Practitioner's Signature _____ Exam Date _____

Address _____ City _____ State _____ Zip _____ Phone (_____) _____

**Acceptable signatures are licensed physician and surgeon, osteopathic physician and surgeon, osteopath, advanced registered nurse practitioner (ARNP), physician's assistant or qualified doctor of chiropractic.*

PARENT AND/OR GUARDIAN AUTHORIZATION & MEDIA RELEASE

I, on my own behalf or as the undersigned parent or legal guardian of the above named applicant (hereafter referred to as the "Athlete"), hereby give permission for the Athlete to participate in Special Olympics programs. I acknowledge that Special Olympics will screen all athletes using the Sex Offender Public Registry and understand that athletes listed on the Registry will be denied participation. I affirm that this Athlete has never been on said Registry or, if Athlete was listed on the Sex Offender Public Registry but has since been removed I will contact Special Olympics Iowa for instructions before submitting this application. I represent and warrant that the Athlete is physically and mentally able to participate in Special Olympics. I understand that if the Athlete has Down Syndrome, he/she cannot participate in sports or events which, by their nature result in hyper-extension, radical flexion or pressure on the neck or upper spine unless a full radiological examination establishes the absence of Atlantoaxial Instability. I am aware that sports and events for which this radiological examination is required are equestrian sports, artistic gymnastics, diving, pentathlon, high jump, alpine skiing, soccer, soccer skills, powerlifting squat and butterfly stroke and diving starts in swimming. On behalf of the Athlete and myself, I acknowledge that the Athlete will be using facilities at his/her own risk and I, on my own behalf, hereby release, discharge and indemnify Special Olympics from all liability for injury to person or damage to property of myself and Athlete. In permitting the Athlete to participate, I am specifically granting permission to Special Olympics Iowa to use the likeness, voice and words of the Athlete in television, radio, films, newspapers, magazines and other media, and in any form not heretofore described, for the purpose of advertising or communicating the purposes and activities of Special Olympics and in appealing for funds to support such activities. I understand that by signing below I consent for the Athlete to participate in the Special Olympics Healthy Athletes Program that provides individual screening assessments of health status and health care needs. The Athlete has no obligation to participate and I understand the Athlete should seek his/her own medical advice and assistance and Special Olympics is not responsible for the Athlete's health. If I am not personally present at Special Olympics activities in which the Athlete is to compete, so as to be consulted 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 Athlete. **Housing Policy:** "I acknowledge that Special Olympics events may involve overnight activities and that housing arrangements for each event may differ. I understand that I should contact my State Program Office if I have any questions about housing arrangements for a specific event or the housing policy in general."

I, THE UNDERSIGNED ADULT ATHLETE, have read and fully understand the provisions of the above release and/or have had them explained. I hereby agree that I will be bound thereby and I shall defend Special Olympics Iowa and hold it harmless from disaffirmation thereof.

Athlete Signature _____

Witness _____ Date _____

I, THE UNDERSIGNED PARENT AND/OR GUARDIAN of the above specified Athlete, have read and fully understand the provisions of the above release and have explained them to the Athlete. I hereby agree that I and said Athlete will be bound thereby, and I shall defend Special Olympics Iowa and hold it harmless from any disaffirmation thereof by said Athlete.

Signature of Parent
 and/or Legal Guardian _____

Print Name _____ Date _____