APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS

INSTRUCTIONS

Before the athlete can participate in Special Olympics, the attached “Application For Participation” form must be completed correctly, postmarked by the appropriate medical deadline date for whichever sport the athlete is participating in (see dates below) and approved by the Program Office. Please contact the Agency Manager or coach to confirm when an existing athlete’s Application For Participation form will expire. You may also check the expiration date for the athlete at http://www.specialolympicswisconsin.org/family_athlete_lookup.aspx. Application For Participation forms may not be faxed to the Program Office.

DEMOGRAPHICS:
Please fill in all of the blanks. Contact the Agency Manager or Coach for the correct Agency name and number.

HEALTH HISTORY:
Every question must be answered either “yes” or “no”. A parent/guardian, caregiver or adult athlete’s signature and date are required.

ATLANTO-AXIAL INSTABILITY ASSESSMENT:
This section is to be completed ONLY for athletes with Down syndrome.

PHYSICAL EXAMINATION:
A licensed physician must complete, sign and date. The physician’s printed name, medical title, address and phone number should appear in the space provided.

Acceptable signatures include: Doctor of Medicine (MD), Doctor of Osteopathy (DO), Physician Assistant (PA) and Nurse Practitioner (NP). In the case of a PA or NP, they should print their name and title, as well as the Physician’s name, title, address and phone.

IF THE REQUIRED INFORMATION IS MISSING, THE FORM WILL BE REJECTED AND RETURNED TO THE AGENCY MANAGER

Mail the Application Form to:

Special Olympics Wisconsin
2310 Crossroads Dr., Suite 1000
Madison, WI 53718

MEDICAL DEADLINE DATES: (There will be no exceptions to these dates)

Bowling & Volleyball

Skiing, Skating, Snowshoeing & Snowboarding

Basketball & Gymnastics

Aquatics, Athletics, Soccer & Powerlifting

Softball, Tee Ball, Tennis, Golf & Bocce

OCTOBER 1

DECEMBER 1

FEBRUARY 1

APRIL 1

JULY 1
APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS
(For individuals with cognitive disabilities)

DEMOGRAPHICS

Agency Name: ___________________________ Agency Number: ___________________________

Athlete

Name: ________________________ _______________ _______________ _______________ _______________ Date of Birth: ____________ / ____ / ________

Social Security Number: ______ - ______ - ______ Home Phone: (____) __________ __________ Race: ___________________________

Gender: [ ] Male [ ] Female

Address: ___________________________ ___________________________ ___________________________ ___________________________ USER

Employer: ___________________________ ___________________________ ___________________________ ___________________________ User

Emergency Contact (if other than parent/guardian): ___________________________ ___________________________ ___________________________ _______________

Health/Accident Insurance Company: ___________________________ ___________________________ Policy Number: ___________________________

PARENT/GUARDIAN INFORMATION

Name: ___________________________ ___________________________ ___________________________ ___________________________ USER

Address (if different): ___________________________ ___________________________ ___________________________ ___________________________ USER

Cell Phone: (____) ___________________________ Home Phone: (____) ___________________________

Emergency Contact: ___________________________ ___________________________ ___________________________ ___________________________ User

Date: ______/______/______

HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER

YES NO

<table>
<thead>
<tr>
<th>Health Item</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disease/Heart Defect/High Blood Pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest Pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizures/Epilepsy/Fainting Spells</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concussion or Serious Head Injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major Surgery or Serious Illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heat Stroke/Exhaustion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blindness/Visual Problem</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Lenses/Glasses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Loss/Hearing Aid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bone or Joint Problem</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neck</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date of most recent tetanus immunization: __________ / ______

(Use separate sheet for additional space.)

Medications:

Please print medication name, amount, date prescribed and number of times per day medication is given. Use separate sheet for additional space.

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dosage</th>
<th>Date Prescribed</th>
<th>Times Per Day</th>
<th>Medication Name</th>
<th>Dosage</th>
<th>Date Prescribed</th>
<th>Times Per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SIGNATURE OF PARENT/CAREGIVER/ADULT ATHLETE: ___________________________ ___________________________ DATE: _____ / _____ / ______

ATLANTO-AXIAL INSTABILITY ASSESSMENT FOR ATHLETES WITH DOWN SYNDROME

PHYSICIAN’S NOTE: If the athlete has Down syndrome, Special Olympics requires a full radiological examination establishing the absence of Atlanto-axial Instability and the completion of the Special Examination Form before he/she may participate in sports or events which, by their nature, may result in hyper-extension, radical flexion or direct pressure on the neck or upper spine. The sports and events for which such a radiological examination is required are: Judo, Equestrian sports, Gymnastics, Diving, Pentathlon, Butterfly stroke and Diving Starts in Swimming, High Jump, Alpine Skiing, Snowboarding, Squat Lift, and Football Team Competition (Soccer).

YES NO

<table>
<thead>
<tr>
<th>X-ray Evaluation</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atlanto-axial Instability</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If yes, was it positive for Atlanto-axial Instability? (Positive indicates that the atlanto-dens interval is 5mm or more)

HAS THE SPECIAL OLYMPICS WISCONSIN SPECIAL EXAMINATION FORM BEEN COMPLETED?

PHYSICAL EXAMINATION

Blood Pressure: __________ / __________ Weight: __________ Height: __________

Normal Abnormal Normal Abnormal Normal Abnormal

<table>
<thead>
<tr>
<th>Vision</th>
<th>Hearing</th>
<th>Oral Cavity</th>
<th>Neck</th>
<th>Extremities</th>
<th>Cardiovascular System</th>
<th>Respiratory System</th>
<th>Gastrointestinal System</th>
<th>Genitourinary System</th>
<th>Skin</th>
<th>Cranial Nerves</th>
<th>Coordination</th>
<th>Reflexes</th>
</tr>
</thead>
</table>

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.

RESTRICTIONS:

PHYSICIAN’S SIGNATURE: ___________________________ DATE: _____ / _____ / ______

Print Physician’s Name & Title: ___________________________

Address: ___________________________ Phone: ___________________________