APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS NORTH DAKOTA

SECTION 1 DEMOGRAPHICS

Program _____ ☐ Male ☐ Female Date of Birth (m/d/y)____/____/____

Athlete's Name _____

Athlete's Address _____ Home Phone # _____

City _____ State _____ Zip _____

Parent/Guardian's Name _____ Work Phone # _____

Parent/Guardian's Address (if different than athlete) _____ Home Phone# _____

City _____ State _____ Zip_____ Email _____

Emergency Contact (if different than parent/guardian) _____ Phone # _____

Health/Accident Insurance Company _____ Policy # _____

SECTION 2 HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER

Yes	No		Yes	No	
☐	☐	Heart Disease/Heart Defect/Highblood Pressure	☐	☐	Sting/Bite Allergies: _____
☐	☐	Chest Pain	☐	☐	General Allergies: _____
☐	☐	Seizures/Epilepsy/Fainting Spells	☐	☐	Special Diet _____
☐	☐	Diabetes	☐	☐	Asthma
☐	☐	Concussion or Serious Head Injury	☐	☐	Uses Tobacco
☐	☐	Major Surgery or Serious Illness	☐	☐	Easy Bleeding
☐	☐	Heat Stroke/Exhaustion	☐	☐	Emotional/Psychiatric/Behavioral Problems
☐	☐	Blindness/Visual Problems (other than corrective lenses)	☐	☐	Shunts
☐	☐	Contact Lenses/Glasses	☐	☐	Down Syndrome (if yes, complete section 3)
☐	☐	Hearing Loss/Hearing Aid	☐	☐	Uses Wheelchair
☐	☐	Bone or Joint Problems	☐	☐	Non-verbal
☐	☐	Medicine Allergies: _____	☐	☐	Immunizations up-to-date
☐	☐	Food Allergies: _____	☐	☐	Other _____

Date of most recent tetanus immunization: ___/___/___

Medication Name	Dosage	Date Pres	Times per day	Medication Name	Dosage	Date Pres	Times per day

Signature of Parent/Caregiver (required) _____ **Date** ____/____/____

SECTION 3 FOR ATHLETES WITH DOWN SYNDROME

Persons with Down Syndrome should have a lateral x-ray of the cervical spine in hyperflexion and hyperextension. The interpretation of the radiographs should include measurements of the atlanto-dens interval.

Yes	No	
☐	☐	Has an x-ray evaluation for atlantoaxial instability been done? If yes, date of x-ray _____
☐	☐	If yes, was it positive for atlantoaxial instability? (positive indicates that the atlanto-dens interval is 5mm or more)

SECTION 4 PHYSICAL EXAMINATION

Blood pressure _____/_____ **Weight:** _____ **Height** _____

Normal/Abnormal		Normal/Abnormal		Normal/Abnormal	
☐	☐ Vision	☐	☐ Cardiovascular system	☐	☐ Cranial nerves
☐	☐ Hearing	☐	☐ Respiratory systme	☐	☐ Coordination
☐	☐ Oral cavity	☐	☐ Gastrointestinal system	☐	☐ Reflexes
☐	☐ Neck	☐	☐ Genitourinary system	Other _____	
☐	☐ Extremities	☐	☐ Skin		

Primary MR Etiology/Category: _____

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: _____

EXAMINER'S SIGNATURE: _____ DATE: _____/_____/_____

EXAMINER'S NAME: _____

ADDRESS: _____ PHONE: _____