370 George Washington Highway
Smithfield, RI 02917
(401) 349-4900 telephone
(401) 349-4936 fax
www.specialolympicsri.org

APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS RHODE ISLAND

(Medical Form for individuals with intellectual disabilities)

Please print clearly and complete ALL sections in their entirety

This application expires three (3) years from the date of the physical exam

DEMOGRAPHICS

Local Program ______________________ Application: (circle one) **NEW** **RENEWAL**

Athlete Information:

Last Name:______________ First Name:______________

Gender: Male_____ Female_____ Date of Birth: ______/______/__________ (Month Day Year)

Street Address:______________________

City:______________ State:________ Zip:__________

Primary Phone:______________

Alternate Phone:______________

Email Address:______________

☐ Add email address to SORI Newsletter mailing list

Parent/Guardian Information:

Name: ______________________

Relation: ______________________

Street Address (if different than Athlete):

____

City: __________ State: _____ Zip:________

Home Phone:______________

Cell Phone: ______________

Email Address: ______________

☐ Add email address to SORI Newsletter mailing list

Emergency Contact (if other than parent/guardian):______________________ **Phone:**______________

Health/Accident Insurance Company:______________________ **Policy Number**:______________

HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER/ADULT ATHLETE

Yes	No		Yes	No		Yes	No	
☐	☐	Heart Problem/High Blood Pressure	☐	☐	Blindness/Impaired Vision	☐	☐	Emotional/Psychiatric/Behavioral
☐	☐	Chest Pain	☐	☐	Contact Lenses/Glasses	☐	☐	Sickle Cell Trait or Disease
☐	☐	Seizures/Epilepsy/Fainting Spells	☐	☐	Hearing Loss/Hearing Aid	☐	☐	Uses a Wheelchair
☐	☐	Diabetes	☐	☐	Bone or Joint Problem	☐	☐	Immunizations Up to Date
☐	☐	Concussion or Serious Head Injury	☐	☐	Asthma (exercise induced wheezing)	☐	☐	Tendency to Bleed Easily
☐	☐	Major Surgery or Serious Illness __________	☐	☐	Tobacco Use	☐	☐	Heat Stroke/Exhaustion

Allergies (list specific): Food______________ Medication______________ General/Insect sting/bites______________

Special Diet______________ Date of last tetanus immunization: ___/___/___ Other:__________

Medications: Is the athlete taking any prescription medications? Yes ☐ **No** ☐ If yes, please list all medications below.

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

Medication Name	Dosage	Date Prescribed	Times Per Day	Medication Name	Dosage	Date Prescribed	Times Per Day

SIGNATURE OF PERSON COMPLETING THIS FORM (PARENT/GUARDIAN/ADULT ATHLETE): ______________

ALSO PRINT NAME: ______________ **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.

YES	NO	
☐	☐	Does the athlete have Down Syndrome
☐	☐	Has an x-ray evaluation for Atlanto-axial Instability been done? **Date of X-Ray**______________
☐	☐	If yes, was it positive for Atlanto-axial Instability? (Positive indicates that the atlanto-dens interval is 5mm or more)

*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).

PHYSICAL EXAMINATION

Blood Pressure: ______/______ **Weight:** __________ **Height:** __________

Normal	Abnormal		Normal	Abnormal		Normal	Abnormal		Normal	Abnormal	
☐	☐	Vision	☐	☐	Extremities	☐	☐	Gastrointestinal System	☐	☐	Cranial Nerves
☐	☐	Hearing	☐	☐	Cardiovascular System	☐	☐	Genitourinary System	☐	☐	Coordination
☐	☐	Oral Cavity	☐	☐	Respiratory System	☐	☐	Skin	☐	☐	Reflexes
☐	☐	Neck	Other:______________								

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.

SPORTS RESTRICTIONS:______________________

EXAMINERS SIGNATURE:______________________ **DATE:**______/______/______ (MONTH DAY YEAR)

Print Examiners Name:______________________ Certification: ☐ MD ☐ DO ☐ DC ☐ PA ☐ ARNP

Address: ______________________

City:______________ State:________ Zip:__________ Phone:______________

SORI use only	New Athlete Recorded in GMS (date: ___________) Initial:__________	**IMPORTANT**: **This is a legal document.** **The following should keep copies of this form: 1) The State Office 2) The Head Coach 3)Athlete's Parent/Legal Guardian All coaches will be responsible for having up-to-date athlete medical forms in their possession at training and competition events and during transportation and travel.**