

APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS CONNECTICUT

LOCAL PROGRAM:			PLEASE CHECK <input type="checkbox"/> NEW <input type="checkbox"/> RENEWAL		
Name (First – Last):					
Date of birth: ____/____/____		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Phone: ()	
Street:					
City:		State:		ZIP Code:	
PARENT OR GUARDIAN INFORMATION					
Name					
Address (if different than athlete's)					
City		State:		ZIP Code:	
Phone Home:		Work:		Mobile:	
E-Mail					
EMERGENCY CONTACT IF DIFFERENT THAN PARENT OR GUARDIAN					
Name:			Phone:		
HEALTH HISTORY					
AN UP TO DATE HEALTH HISTORY AND A PHYSICAL EXAMINATION PERFORMED BY A LICENSED PHYSICIAN IS REQUIRED UPON ENTRY INTO THE PROGRAM. A PHYSICAL EXAMINATION IS REQUIRED EVERY 3 YEARS FOR ATHLETES WITH "YES" RESPONSES TO ITEMS 1 -5. A PHYSICAL EXAMINATION IS REQUIRED FOR ALL ATHLETES WITH A "NEW PROBLEM" RESPONSE TO ITEMS 7-11. ATHLETES MUST SUBMIT THIS FORM EVERY 3 YEARS WHETHER OR NOT AN EXAMINATION IS NECESSARY.					
1. HEART PROBLEMS <input type="checkbox"/> YES <input type="checkbox"/> NO		9. SURGERY OR ILLNESS <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NEW		17. EMOTIONAL/BEHAVIOR PROBLEMS <input type="checkbox"/> YES <input type="checkbox"/> NO	
2. CHEST PAINS <input type="checkbox"/> YES <input type="checkbox"/> NO		10. HEAT STROKE/COLD ILLNESS <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NEW		18. BONE OR JOINT DISORDER <input type="checkbox"/> YES <input type="checkbox"/> NO	
3. SEIZURES/EPILEPSY <input type="checkbox"/> YES <input type="checkbox"/> NO		11. OTHER PROBLEM (S) THAT WOULD INTERFERE		19. SICKLE CELL/TRAIT DISEASE <input type="checkbox"/> YES <input type="checkbox"/> NO	
4. DIABETES <input type="checkbox"/> YES <input type="checkbox"/> NO		WITH SPORTS PARTICIPATION <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NEW		20. HEARING LOSS/ HEARING AID <input type="checkbox"/> YES <input type="checkbox"/> NO	
5. DOWN SYNDROME <input type="checkbox"/> YES <input type="checkbox"/> NO		LIST: _____		21. CONTACTS/EYEGLASSES <input type="checkbox"/> YES <input type="checkbox"/> NO	
NECK X-RAY DONE <input type="checkbox"/> YES <input type="checkbox"/> NO		12. IMPAIRED MOBILITY <input type="checkbox"/> YES <input type="checkbox"/> NO		22. DENTURES/FALSE TEETH <input type="checkbox"/> YES <input type="checkbox"/> NO	
INSTABILITY PRESENT <input type="checkbox"/> YES <input type="checkbox"/> NO		13. USES A WHEELCHAIR <input type="checkbox"/> YES <input type="checkbox"/> NO		23. DATE OF LAST TETANUS SHOT ____/____/____	
6. BLINDNESS/VISION PROBLEM <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NEW		14. SPECIAL DIET <input type="checkbox"/> YES <input type="checkbox"/> NO		24. LIST ALLERGY TO: INSECT STING <input type="checkbox"/> YES <input type="checkbox"/> NO	
7. ABSENCE OF KIDNEY/TESTICLE <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NEW		15. ASTHMA <input type="checkbox"/> YES <input type="checkbox"/> NO		MEDICINE _____ <input type="checkbox"/> YES <input type="checkbox"/> NO	
8. HEAD INJURY/CONCUSSION <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NEW		16. BLEEDING PROBLEMS <input type="checkbox"/> YES <input type="checkbox"/> NO		FOODS _____ <input type="checkbox"/> YES <input type="checkbox"/> NO	
ADDITIONAL COMMENTS:					
MEDICATIONS: PLEASE PRINT MEDICATION NAME, AMOUNT AND NUMBER OF TIMES PER DAY MEDICATION NEEDS TO BE TAKEN:					
SIGNATURES					
EXAMINERS NOTE: If an athlete has Down Syndrome, Special Olympics requires a full radiological examination establishing the absence of Atlanto-axial Instability before he/she may participate in sports or events which, by their nature may result in hyperextension, radical flexion or direct pressure on the neck or upper spine. The sports and events for which such a radiological examination is required are equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, squat lift and football team competition (soccer).					
RESTRICTIONS:				DATE: ____/____/____	
EXAMINERS SIGNATURE:				DATE: ____/____/____	
EXAMINERS NAME:				PHONE: ()	
APPLICANT OR PARENT/GUARDIAN SIGNATURE:				DATE: ____/____/____	
THIS FORM MUST BE COMPLETED LEGIBLY, SIGNED AND DATED TO BE CONSIDERED VALID.					