



Special Olympics Arizona  
 3816 North 7<sup>th</sup> Street  
 Phoenix, AZ 85014-5004  
 602-230.1200/800.289.4946  
 Fax: 602.230.1110

**MEDICAL/PARENTAL RELEASE FORM**

PROGRAM NAME: \_\_\_\_\_

AREA #: \_\_\_\_\_ PROGRAM #: \_\_\_\_\_

**DEMOGRAPHICS**

Athlete's First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_  
 Athlete's Social Security # (Optional): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Gender: Male  Female   
 Athlete's Date of Birth: (M/D/Y) \_\_\_\_/\_\_\_\_/\_\_\_\_ Athlete's Email Address: \_\_\_\_\_  
 Athlete's Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Athlete's Home Phone #: (\_\_\_\_) \_\_\_\_\_  
 Parent/Guardian's Name: \_\_\_\_\_  
 Parent/Guardian's Address (If different than above): \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Parent Primary Phone #: (\_\_\_\_) \_\_\_\_\_ Parent Email Address: \_\_\_\_\_  
 Emergency Contact Name (if other than parent/guardian): \_\_\_\_\_  
 Emergency Contact Phone #: (\_\_\_\_) \_\_\_\_\_  
 Health/Accident Insurance Co: \_\_\_\_\_ Policy #: \_\_\_\_\_

**HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER**

<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease/Heart Defect/High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Requires Extra Supervision	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Deaf	<input type="checkbox"/>	<input type="checkbox"/>	Heat Stroke/Exhaustion
<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy/Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss/Hearing Aid	<input type="checkbox"/>	<input type="checkbox"/>	Shunts
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain
<input type="checkbox"/>	<input type="checkbox"/>	Blind	<input type="checkbox"/>	<input type="checkbox"/>	Concussion/Head injury	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Visually Impaired	<input type="checkbox"/>	<input type="checkbox"/>	Major Surgery/Serious Illness	<input type="checkbox"/>	<input type="checkbox"/>	Bone or Joint Problem
<input type="checkbox"/>	<input type="checkbox"/>	Contact Lenses/Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Immunizations up to Date	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Trait or Disease
<input type="checkbox"/>	<input type="checkbox"/>	Allergies: Insect Stings/Bites: _____	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet _____			
<input type="checkbox"/>	<input type="checkbox"/>	Allergies: Food: _____	<input type="checkbox"/>	<input type="checkbox"/>	Emotional/Psychiatric/Behavioral			
<input type="checkbox"/>	<input type="checkbox"/>	Allergies: Medicines: _____	<input type="checkbox"/>	<input type="checkbox"/>	Other _____			

Date of most recent Tetanus Immunization: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 MEDICATIONS: Please print medication name, amount, date prescribed and number of times per day given. All changes in medication should be submitted to Special Olympics Arizona. For more space, attach additional paper.

Medication Name	Dosage	Date Prescribed	Times Per Day

Signature of parent/caregiver/adult athlete: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PHYSICAL EXAMINATION: TO BE COMPLETED BY MEDICAL EXAMINER**

Blood Pressure: \_\_\_\_/\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

<b>Normal/Abnormal</b>	<b>Normal/Abnormal</b>	<b>Normal/Abnormal</b>	<b>Normal/Abnormal</b>
<input type="checkbox"/> <input type="checkbox"/> Vision	<input type="checkbox"/> <input type="checkbox"/> Cardiovascular System	<input type="checkbox"/> <input type="checkbox"/> Cranial Nerves	<input type="checkbox"/> <input type="checkbox"/> Skin
<input type="checkbox"/> <input type="checkbox"/> Hearing	<input type="checkbox"/> <input type="checkbox"/> Respiratory System	<input type="checkbox"/> <input type="checkbox"/> Genitourinary System	<input type="checkbox"/> <input type="checkbox"/> Neck
<input type="checkbox"/> <input type="checkbox"/> Oral Cavity	<input type="checkbox"/> <input type="checkbox"/> Gastrointestinal System	<input type="checkbox"/> <input type="checkbox"/> Coordination	<input type="checkbox"/> <input type="checkbox"/> Reflexes
			<input type="checkbox"/> <input type="checkbox"/> Extremities

Other: \_\_\_\_\_  
 Primary MR: \_\_\_\_\_

**ATLANTO-AXIAL INSTABILITY ASSESSMENT FOR ATHLETES WITH DOWN SYNDROME**

Examiner's Note: If the 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 hypertension, 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, artistic gymnastics, diving, pentathlon, butterfly stroke and diving starts in swimming, high jump, alpine skiing, snowboarding, squat lift, and football team competition (soccer). **PLEASE CIRCLE THE FOLLOWING:** Does the athlete have Down Syndrome? **Yes No**  
 If yes, has an x-ray for Atlanto-axial instability been done? **Yes No** (If no, the athlete will be restricted from above sports/events.)  
**X-Ray Date:** \_\_\_\_\_ If yes, was it positive for Atlanto-axial instability? (the Atlanto-dens interval is 5mm or more) **Yes No** If yes, the athlete will be restricted from above sports/events unless the "Special Release for Athletes with Atlanto-Axial Instability" form is completed.  
**I have reviewed the above health information and have preformed 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: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

This form is valid for 3 years unless otherwise stated. Optional expiration date: \_\_\_\_/\_\_\_\_/\_\_\_\_ **REV: 5/2003**