

Medical Form and Application For Athlete Participation in Special Olympics New Hampshire

Local Program Name: _____

T-shirt Size _____ Sex: Male Female Date of Birth ____/____/____

Athlete Name _____ Home Phone _____

Home Address _____ Work Phone _____

_____ Home Email _____

Parent/Guardian Name _____ Relationship to Athlete _____

Address (If different than athlete) _____

Parent/Guardian: Please check if you do not wish to receive mailings from SONH:

Emergency Contact/Relationship _____ / _____ Primary Phone _____

Health/Accident Insurance Company _____ Policy No. _____

SECTION A - Athlete Health Information

- | | |
|--|---|
| <p><input type="checkbox"/> Yes <input type="checkbox"/> No 1. Heart Disease/Heart Defect/High Blood Pressure</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 2. Chest Pain or Fainting Spells</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 3. Seizures/Epilepsy</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 4. Diabetes</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 5. Down syndrome</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No - Have cervical spine (neck bone) x-rays been done?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No - Atlanto Axial Instability</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 6. Parent/Sibling (Under 40) Died of Heart Disease</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 7. Absence of Vision/Blind in One Eye</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 8. Absence of One Kidney or Testicle</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 9. Concussion or Serious Head Injury</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 10. Major Surgery or Serious Illness</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 11. Heat Stroke/Exhaustion</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 12. Other Problems that would interfere with sports participation: _____</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No 13. Uses Wheelchair</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 14. Impaired Motor Ability</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 15. Allergy to the Following (list specific)</p> <p>Medicine _____</p> <p>Foods _____</p> <p>Insect Sting/Bite _____</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 16. Special Diet</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 17. Exercise-Induced Wheezing</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 18. Tendency to Bleed Easily</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 19. Emotional/Psychiatric/Behavioral Problems</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 20. Serious Bone or Joint Disorder</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 21. Sickle Cell Trait or Disease</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 22. Hearing Aid/Hearing Loss</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 23. Contact Lenses/Eyeglasses</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 24. Dentures/False Teeth</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 25. Immunizations (shots) are up to date</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No 26. Date of Last Tetanus Shot ____/____/____</p> |
|--|---|
- Comments: _____

Medications – Please print medication name, dosage, date prescribed and number of times per day medication is taken.

Medication Name	Dosage	Date Prescribed	Times per Day

Signature (Adult Athlete or Parent/Guardian) _____ Date ____/____/____

SECTION B – Medical Certification

A physical examination performed by a licensed examiner (medical doctor, physician's assistant or nurse practitioner) is required for participation every three years.

Note: If the athlete has Down syndrome, Special Olympics requires a full radiological examination once to establish the absence of Atlanto-Axial Instability before he/she may participate in sports 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 radiological examination is required are: equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, squat lift and soccer team competition.

I have reviewed the above health information, and examined the athlete named in the application, and certify there is no medical evidence available to me which would preclude the athlete's participation in Special Olympics.

Restrictions _____ **Date** ____/____/____

Examiner's Name _____ **Signature** _____ **Phone** _____

Address _____