ATHLETE NAME: _____ DATE OF BIRTH: ____/____/____

APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS

Please print clearly and complete all sections in their entirety.
This application expires three (3) years from the date of exam.
People are eligible for Special Olympics provided they are age 8 or above and are considered to have an intellectual disability or closely related developmental disability, defined as functional limitations in both general learning and two or more adaptive skill areas: communication, leisure, self-direction, home living, community use, work, health and safety, academics, self-care and social skills.

State Office ONLY:
Delegation: _____
☐ Updated Form
☐ New Athlete
☐ in GMS
☐ not in GMS

Send completed forms to: SOMN, 900 2nd Ave S, Ste 300 Minneapolis, MN 55402
Email: athletepaperwork@somn.org Fax: 612.333.8782

SECTION A: DEMOGRAPHICS (Required)

Delegation: _____
Athlete Name: _____
Athlete Address: _____
City: _____ State: _____ Zip: _____
Parent/Guardian Name: _____
Parent/Guardian Address (if different than athlete): _____
City: _____ State: _____ Zip: _____
Emergency Contact (if other than Parent/Guardian): _____
Emergency Contact Relationship to Athlete: _____

☐ Male ☐ Female Date of Birth: ____/____/____
Athlete Primary Phone: (_____) _____ (Circle one) home work cell
Athlete Email: _____
Parent Primary Phone: (_____) _____ (Circle one) home work cell
Parent Alternate Phone: (_____) _____ (Circle one) home work cell
Parent Email: _____
Emergency Contact Phone: (_____) _____ (Circle one) home work cell
Health/Accident Insurance Company: _____
Policy #: _____

SECTION B: HEALTH HISTORY (MAY BE COMPLETED BY PARENT/GUARDIAN) (Required)

PLEASE INDICATE **YES** OR **NO** FOR **ALL** AREAS

Yes	No		Yes	No	
☐	☐	Allergies: _____	☐	☐	Heat Stroke/Exhaustion
☐	☐	Asthma	☐	☐	Immunizations up-to-date
☐	☐	Blindness/Visual Problems (other than corrective lenses)	☐	☐	Major Surgery or Serious Illness _____
☐	☐	Bone or Joint Problem	☐	☐	Non-verbal
☐	☐	Chest Pain	☐	☐	Seizures/Epilepsy/Fainting Spells
☐	☐	Concussion or Serious Head Injury: _____	☐	☐	Sickle Cell Trait or Disease
☐	☐	Contact Lenses/Glasses	☐	☐	Special Diet _____
☐	☐	Diabetes	☐	☐	Uses Tobacco
☐	☐	Down Syndrome ***(If Yes, see next page)***	☐	☐	Uses Wheelchair
☐	☐	Easy Bleeding	☐	☐	Other: _____ *(for additional space, please see reverse side)*
☐	☐	Heart Disease/Heart Defect/High Blood Pressure	☐	☐	Have you ever been convicted or charged with a criminal offense other than minor traffic violations?
☐	☐	Hearing Loss/Hearing Aid			
☐	☐	Emotional/Psychiatric/Behavioral Problems			

Medications: ☐ None ☐ Listed Below

☐ **BY CHECKING HERE**, I CONFIRM THAT I HAVE READ AND UNDERSTAND THE CONCUSSION AWARENESS & SAFETY RECOGNITION POLICY FOUND AT **www.specialolympicsminnesota.org/concussion-policy**

Medication Name	Dosage	Date Prescribed	Times per day	Medication Name	Dosage	Date Prescribed	Times per day

REQUIRED Signature of Parent/Guardian _____ Date: ____/____/____
Athletes can sign only if they are their own guardian.

Printed Name _____ Relationship to Athlete _____ (Required)

This form was updated Dec. 2021.

ATHLETE NAME DATE OF BIRTH: ____ / ____ / ____

SECTION C: PHYSICAL EXAMINATION

Must be completed by a licensed medical practitioner - **ALL** boxes must be marked

Blood Pressure: _____ / _____ Weight: _____ Height: _____

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

Date of most recent tetanus immunization: ____ / ____ / ____ Date of most recent COVID-19 immunization: ____ / ____ / ____

In order to qualify to participate as a Special Olympics athlete, a person must be considered to have an intellectual disability or closely related developmental disability defined as functional limitations in both general learning and two or more adaptive skills areas: communication, leisure, self-direction, home living, community use, work, health and safety, academics, self-care and social skills. Persons whose functional limitations are based solely on a physical, behavioral, or emotional disability, or a specific learning or sensory disability, are not eligible to participate as Special Olympics athletes.

☐ **Yes** ☐ **No** **Does this person have an intellectual disability?**

Please list intellectual disability: _____

Restrictions: _____

ATLANTO-AXIAL ASSESSEMENT FOR ATHLETES WITH DOWN SYNDROME ONLY

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 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 and diving starts in swimming, high jump, alpine skiing, snowboarding, squat lift and soccer.

Yes	No	
☐	☐	Does the athlete participate in a restricted sport or event? If yes or unknown, an x-ray for atlanto-axial instability must be done.
☐	☐	Has an x-ray evaluation for atlanto-axial instability been done? Date: _____
☐	☐	If yes, was the x-ray positive for atlanto-axial instability? Positive indication is the atlanto-dens interval is 5mm or more.

Please list any additional information that may be helpful to know about this athlete: _____

_____

_____

**THE EXAMINER'S SIGNATURE, DATE OF EXAM AND CLINIC INFO BELOW ARE REQUIRED INFORMATION FOR SECTION C OF THIS APPLICATION TO BE COMPLETE. IF SUBMITTING AN ELECTRONICALLY GENERATED FORM, IT MUST CONTAIN INDICATION OF AN ELECTRONIC SIGNATURE AND THE CONTACT INFORMATION BELOW.* I HAVE REVIEWED THE ABOVE HEALTH INFORMATION AND HAVE PERFORMED THE ABOVE EXAMINATION ON THIS ATHLETE AND BY SIGNING BELOW I CERTIFY THAT THE ATHLETE CAN PARTICIPATE IN SPECIAL OLYMPICS.

REQUIRED ***Examiner's Signature:** _____ *Date of exam: ____ / ____ / ____

*Examiner's Name: _____

*Clinic Name: _____

Address (City, State, Zip): _____

Phone: (_____) _____