PARTICIPANT RELEASE FORM

Special Olympics Georgia

I want to take part in Special Olympics and agree to the following:

1. **Able to Participate.** I am able to take part in Special Olympics. I know there is a risk of injury.
2. **Photo Release.** Special Olympics organizations may use my picture, video, name, voice, and words to promote Special Olympics.
3. **Overnight Stay.** For some events, I may stay in a hotel, college dorm or someone's home. If I have questions, I will ask.

SOGA Housing Policy – Special Olympics Georgia (SOGA) usually provides housing for Athletes, Unified Partners and Coaches entered in each State Games. SOGA totals the number of male and female Athletes, Unified Partners and Coaches per agency and assigns room allotments based on those totals. When determining allotted room numbers, SOGA allocates and provides 4 persons of the same gender per room for a Double/Double or King room with a pullout, 2 persons of the same gender per room for a King room and 5 persons of the same gender per room for a Queen/Queen with a pullout. In dorm rooms, SOGA allots one bed per person. Athletes, Unified Partners, Coaches and general volunteers may not share a room with Athletes, Unified Partners, Coaches and general volunteers of the opposite sex.

4. **Emergency Care.** I consent to medical care if needed in an emergency, unless I check one of these boxes:

   ☐ I have a religious or other objection to receiving medical treatment.
   ☐ I do not consent to blood transfusions.
   (If either box is checked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)

5. **Health Programs.** If I take part in a health program, I consent to health activities, exams, and treatment. This should not replace regular health care. I can say no to treatment or anything else any time.

6. **Personal Information.** I understand my information may be used and shared by Special Olympics to: Make sure I am eligible and can participate safely; Run trainings and events and share results; Put my information in a computer system; Provide health treatment, make referrals, consult doctors, and remind me about follow-up services; Research, share, and respond to needs of Special Olympics participants (identifying information removed if shared publicly); and Protect health and safety, respond to government requests, and report information required by law. I can ask to see and revise my information. I can ask to limit how my information is used.

7. **Concussions.** I understand the risk of concussions and continuing to play sports with a concussion. I may have to get medical care if I have a suspected concussion. I also may have to wait 7 days or more and get permission from a doctor before I start playing sports again.

8. **Communicable Disease(s).** Participation includes possible exposure to and illness from infectious and/or communicable diseases including but not limited to MRSA, influenza, and COVID-19. While particular rules and personal discipline may reduce this risk, the risk of serious illness and death does exist; and, I KNOWINGLY AND FREELY ASSUME ALL SUCH RISKS, both known and unknown, EVEN IF ARISING FROM THE NEGLIGENCE OF THE RELEASEES or others, and assume full responsibility for my participation; and, I willingly agree to comply with the stated and customary terms and conditions for participation as regards protection against infectious diseases. If, however, I observe and any unusual or significant hazard during my presence or participation, I will remove myself from participation and bring such to the attention of the nearest official immediately; and, I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, HEREBY RELEASE AND HOLD HARMLESS Special Olympics, Inc, Special Olympics *Georgia* their officers, officials, agents, and/or employees, other participants, sponsoring agencies, sponsors, advertisers, and if applicable, owners and lessors of premises used to conduct the event ("RELEASEES"), WITH RESPECT TO ANY AND ALL ILLNESS, DISABILITY, DEATH, or loss or damage to person or property, WHETHER ARISING FROM THE NEGLIGENCE OF RELEASEES OR OTHERWISE, to the fullest extent permitted by law.

PARTICIPANT NAME (PRINT): _____

PARTICIPANT SIGNATURE (required if over 18 years old and signing on own behalf)
I have read and understand this release. If I have questions, I will ask. By signing, I agree to this form.

Participant Signature: _____ **Date:** _____

PARENT/GUARDIAN SIGNATURE (required if under 18 years old or has a legal guardian)
I am a parent or guardian of the Participant. I have read and understand this form and have explained the contents to the Participant as appropriate. By signing, I agree to this form on my own behalf and on behalf of the Participant.

Parent/Guardian Signature: _____ **Date:** _____

Printed Name: _____ **Relationship:** _____

(You cannot alter this form under any circumstances)

Athlete Medical Form – HEALTH HISTORY

(pages 1 & 2 to be completed by the athlete or parent/guardian/caregiver)

Must Complete ALL Items on these two pages

Special Olympics Georgia

AREA & AGENCY:

ATHLETE INFORMATION

Female: ☐ Male: ☐ Other Gender Identity: ☐

First Name: Middle Name:

Last Name:

Date Birth *(mm/dd/yyyy)*:

Address (Street):

Address (City, State, Zip):

Phone: Cell:

E-mail:

Athlete Employer, if any:

Eye color: *I am my own guardian.* ☐ Yes ☐ No

Race/Ethnicity:

☐ American Indian/Alaskan ☐ Asian American

☐ Black or African ☐ Native Hawaiian or Other Pacific

☐ White or Caucasian ☐ Hispanic or Latinx

☐ Prefer not to answer ☐ More than one race

Does the athlete have *(check any that apply)*:

☐ Fragile X Syndrome ☐ Down syndrome

☐ Autism ☐ Fetal Alcohol Syndrome

☐ Cerebral Palsy

Other syndrome, please specify:

Is the athlete allergic to any of the following *(please list)*:

☐ Latex ☐ No Known Allergies

☐ Medications:

☐ Insect Bites or Stings:

☐ Food:

List any special dietary needs:

List all past surgeries:

☐ PARENT ☐ GUARDIAN INFORMATION *(if not own guardian)*

Name:

Phone: Cell:

E-mail:

Emergency Contact Name: Same as Above: ☐

Emergency Contact Phone (cell):

Emergency Contact Relationship:

Does the athlete have a primary care physician? ☐ Yes ☐ No *If yes, list.*

Physician Name: Physician Phone:

Insurance Policy (Company and Number):

Does the athlete have any objections to emergency medical care?

☐ No ☐ Yes ***If yes, contact your local Program to get the Emergency Care Refusal Form.***

LIST ANY SPORTS THE ATHLETE WISHES TO PLAY:

Has a doctor ever limited the athlete's participation in sports?

☐ No ☐ Yes *If yes, please describe:*

Has the athlete ever had an abnormal Electrocardiogram (EKG) or Echocardiogram (Echo)? *If yes, select below and describe.*

☐ Yes, had abnormal EKG ☐ Yes, had abnormal Echo

Does the athlete currently have any chronic or acute infection?

☐ No ☐ Yes *If yes, please describe:*

Does the athlete use: *(check any that apply)*:

☐ Brace ☐ Colostomy ☐ Communication Device

☐ C-PAP Machine ☐ Crutches or Walker ☐ Dentures

☐ Glasses or Contacts ☐ G-Tube or J-Tube ☐ Hearing Aid

☐ Implanted Device ☐ Inhaler ☐ Pacemaker

☐ Removable Prosthetics ☐ Splint ☐ Wheel Chair

Has the athlete had a Tetanus vaccine in the past 7 years? ☐ No ☐ Yes

FAMILY HISTORY

Has any relative died of a heart problem before age 50? ☐ No ☐ Yes

Has any family member or relative died while exercising? ☐ No ☐ Yes

List all medical conditions that run in the athlete's family:

Athlete Medical Form – HEALTH HISTORY

(pages 1 & 2 to be completed by athlete or parent/guardian/caregiver)

Special Olympics Georgia

Athlete's Name:

HAS THE ATHLETE EVER BEEN DIAGNOSED WITH OR EXPERIENCED ANY OF THE FOLLOWING CONDITIONS

Loss of Consciousness	☐ No	☐ Yes	High Blood Pressure	☐ No	☐ Yes	Stroke/TIA	☐ No	☐ Yes
Dizziness during or after exercise	☐ No	☐ Yes	High Cholesterol	☐ No	☐ Yes	Concussions	☐ No	☐ Yes
Headache during or after exercise	☐ No	☐ Yes	Vision Impairment	☐ No	☐ Yes	Asthma	☐ No	☐ Yes
Chest pain during or after exercise	☐ No	☐ Yes	Hearing Impairment	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes
Shortness of breath during or after exercise	☐ No	☐ Yes	Enlarged Spleen	☐ No	☐ Yes	Hepatitis	☐ No	☐ Yes
Irregular, racing or skipped heart beats	☐ No	☐ Yes	Single Kidney	☐ No	☐ Yes	Urinary Discomfort	☐ No	☐ Yes
Congenital Heart Defect	☐ No	☐ Yes	Osteoporosis	☐ No	☐ Yes	Spina Bifida	☐ No	☐ Yes
Heart Attack	☐ No	☐ Yes	Osteopenia	☐ No	☐ Yes	Arthritis	☐ No	☐ Yes
Cardiomyopathy	☐ No	☐ Yes	Sickle Cell Disease	☐ No	☐ Yes	Heat Illness	☐ No	☐ Yes
Heart Valve Disease	☐ No	☐ Yes	Sickle Cell Trait	☐ No	☐ Yes	Broken Bones	☐ No	☐ Yes
Heart Murmur	☐ No	☐ Yes	Easy Bleeding	☐ No	☐ Yes	Dislocated Joints	☐ No	☐ Yes
Endocarditis	☐ No	☐ Yes						

Difficulty controlling bowels or bladder ☐ No ☐ Yes

If yes, is this new or worse in the past 3 years? ☐ No ☐ Yes

Numbness or tingling in legs, arms, hands or feet ☐ No ☐ Yes

If yes, is this new or worse in the past 3 years? ☐ No ☐ Yes

Weakness in legs, arms, hands or feet ☐ No ☐ Yes

If yes, is this new or worse in the past 3 years? ☐ No ☐ Yes

Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet ☐ No ☐ Yes

If yes, is this new or worse in the past 3 years? ☐ No ☐ Yes

Head Tilt ☐ No ☐ Yes

If yes, is this new or worse in the past 3 years? ☐ No ☐ Yes

Spasticity ☐ No ☐ Yes

If yes, is this new or worse in the past 3 years? ☐ No ☐ Yes

Paralysis ☐ No ☐ Yes

If yes, is this new or worse in the past 3 years? ☐ No ☐ Yes

Describe any past broken bones or dislocated joints *(if yes is checked for either of those fields above):*

Epilepsy or any type of seizure disorder ☐ No ☐ Yes

If yes, list seizure type:

If yes, had seizure during the past year? ☐ No ☐ Yes

Self-injurious behavior during the past year ☐ No ☐ Yes

Aggressive behavior during the past year ☐ No ☐ Yes

Depression (diagnosed) ☐ No ☐ Yes

Anxiety (diagnosed) ☐ No ☐ Yes

Describe any additional mental health concerns:

List any other ongoing or past medical conditions:

PLEASE LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW *(includes inhalers, birth control or hormone therapy)*

Medication, Vitamin or Supplement	*Dosage*	*Times per Day*	*Medication, Vitamin or Supplement*	*Dosage*	*Times per Day*	*Medication, Vitamin or Supplement*	*Dosage*	*Times per Day*

Is the athlete able to administer his or her own medications? ☐ No ☐ Yes

If female athlete, list date of last menstrual period:

Name of Person Completing this Form **Relationship to Athlete** **Phone** **Email**

Athlete Medical Form – PHYSICAL EXAM

(to be completed by a Medical Professional only)

Special Olympics Georgia

Athlete's Name:

MEDICAL PHYSICAL INFORMATION *(TO BE COMPLETED BY EXAMINER ONLY)*

Height	Weight	BMI *(optional)*	Temperature	Pulse	O_2Sat	Blood Pressure		Vision
cm	kg	BMI	C			BP Right	BP Left	Right Vision 20/40 or better ☐No ☐Yes ☐N/A
in	lbs	Body Fat %	F					Left Vision 20/40 or better ☐No ☐Yes ☐N/A

Right Hearing (Finger Rub)	☐Responds	☐No Response	☐Can't Evaluate			Bowel Sounds	☐No	☐Yes	
Left Hearing (Finger Rub)	☐Responds	☐No Response	☐Can't Evaluate			Hepatomegaly	☐No	☐Yes	
Right Ear Canal	☐Clear	☐Cerumen	☐Foreign Body			Splenomegaly	☐No	☐Yes	
Left Ear Canal	☐Clear	☐Cerumen	☐Foreign Body			Abdominal Tenderness	☐No	☐RUQ	☐RLQ ☐LUQ ☐LLQ
Right Tympanic Membrane	☐Clear	☐Perforation	☐Infection	☐NA		Kidney Tenderness	☐No	☐Right	☐Left
Left Tympanic Membrane	☐Clear	☐Perforation	☐Infection	☐NA		Right upper extremity reflex	☐Normal	☐Diminished	☐Hyperreflexia
Oral Hygiene	☐Good	☐Fair	☐Poor			Left upper extremity reflex	☐Normal	☐Diminished	☐Hyperreflexia
Thyroid Enlargement	☐No	☐Yes				Right lower extremity reflex	☐Normal	☐Diminished	☐Hyperreflexia
Lymph Node Enlargement	☐No	☐Yes				Left lower extremity reflex	☐Normal	☐Diminished	☐Hyperreflexia
Heart Murmur (supine)	☐No	☐1/6 or 2/6	☐3/6 or greater			Abnormal Gait	☐No	☐Yes, describe below	
Heart Murmur (upright)	☐No	☐1/6 or 2/6	☐3/6 or greater			Spasticity	☐No	☐Yes, describe below	
Heart Rhythm	☐Regular	☐Irregular				Tremor	☐No	☐Yes, describe below	
Lungs	☐Clear	☐Not clear				Neck & Back Mobility	☐Full	☐Not full, describe below	
Right Leg Edema	☐No	☐1+ ☐2+	☐3+	☐4+		Upper Extremity Mobility	☐Full	☐Not full, describe below	
Left Leg Edema	☐No	☐1+ ☐2+	☐3+	☐4+ Radial		Lower Extremity Mobility	☐Full	☐Not full, describe below	
Pulse Symmetry	☐Yes	☐R>L	☐L>R			Upper Extremity Strength	☐Full	☐Not full, describe below	
Cyanosis	☐No	☐Yes, describe				Lower Extremity Strength	☐Full	☐Not full, describe below	
Clubbing	☐No	☐Yes, describe				Loss of Sensitivity	☐No	☐Yes, describe below	

ATLANTO-AXIAL INSTABILITY (AAI)

☐ Athlete shows NO EVIDENCE of neurological symptoms or physical findings associated with spinal cord compression or atlantoaxial instability.

☐ Athlete has neurological symptoms or physical findings that could be associated with spinal cord compression or atlantoaxial instability and must receive an additional neurological evaluation to rule out additional risk of spinal cord injury prior to clearance for sports participation.

RECOMMENDATIONS *(TO BE COMPLETED BY EXAMINER ONLY)*

Licensed Medical Examiners: It is recommended that the examiner review items on the medical history with the athlete or their guardian, prior to performing the physical exam. If an athlete needs further medical evaluation please use the Special Olympics Further Medical Evaluation Form, page 4, to provide the athlete with medical clearance..

☐ **This athlete is ABLE to participate in Special Olympics sports without restrictions/limitations**

☐ **This athlete is ABLE to participate in Special Olympics sports** WITH **restrictions/limitations** →

☐ **This athlete** MAY NOT participate **in Special Olympics sports at this time and MUST be further evaluated by a physician for the following concerns:**

Concerning Cardiac Exam — Acute Infection — Stage II Hypertension or Greater

Concerning Neurological Exam — O_2 Saturation Less than 90% on Room Air — Hepatomegaly or Splenomegaly

Other, please describe:

Additional Licensed Examiner's Notes and Recommended Follow-up:

☐ Follow up with a cardiologist ☐ Follow up with a neurologist ☐ Follow up with a primary care physician

☐ Follow up with a vision specialist ☐ Follow up with a hearing specialist ☐ Follow up with a dentist or dental hygienist

☐ Follow up with a podiatrist ☐ Follow up with a physical therapist ☐ Follow up with a nutritionist

☐ Other/Exam Notes:

Licensed Medical Examiner's Signature **Date of Exam**

Name:

E-mail:

Phone: License: