

Athlete Application for Participation

(Valid for 3 Years from the Date of the Physical Exam)



Please print clearly. All information is required.

Section (North/South/West) _____ Local Program (Number/Name) _____

Name _____

Social Security Number (optional) _____ Male Female Date of Birth _____ / _____ / _____ Phone # _____ - _____ - _____

Street Address or PO Box _____ Apt # _____

City/Town _____ State _____ ZIP Code + 4 _____ - _____ - _____

Emergency Contact Name _____ Emergency Contact Phone # _____ - _____ - _____

HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER

<table border="0"> <tr><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td><td>Allergies:</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td> <i>Environmental:</i> _____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td> <i>Food:</i> _____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td> <i>Insect stings/bites:</i> _____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td> <i>Medicine Allergies:</i> _____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Asthma*</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Blind*</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td> <i>Visually impaired</i></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Bone or joint problem</td></tr> <tr><td><input 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(* Requires physical examination if new problem)

Medications (if applicable): Please print medication name, amount, date prescribed and number of times per day medication are given.

Medication Name	Dosage	Date Presc.	Times per day	Medication Name	Dosage	Date Presc.	Times per day

Special Olympics Massachusetts (SOMA) specifically has my permission (both during participation and anytime thereafter) to use my/my child's/my ward's likeness, name, voice, and words in television, radio, film, newspaper, magazines, and any other media, and in any form, for the purpose of advertising or communicating the purposes and activities of SOMA; as well as participating in the Healthy Athlete Initiative.

I understand that if a medical emergency should arise during my/my child's/my ward's participation in any SOMA activity and I am not able to give my consent for treatment, that SOMA is authorized to take whatever measures are necessary to protect my health and well-being including hospitalization.

Signature of parent/legal guardian/adult athlete (over 18) _____ Date _____ / _____ / _____

SECTIONS BELOW TO BE COMPLETED BY EXAMINING PHYSICIAN (form is not valid until every section is filled out):

1.) For athletes with Down syndrome: Persons with Down syndrome should have a lateral x-ray of the cervical spine in hyper flexion and hyperextension. The interpretation of the radiographs should include measurements of the atlanto-dens interval.

Yes No

Has an x-ray evaluation for atlantoaxial instability been done? Date of x-ray: _____ / _____ / _____

If yes, was it positive for atlantoaxial instability? (positive indicates that the atlanto-dens interval is 5mm or more)

2.) RESTRICTIONS: _____

3.) Signature of Examiner: _____ Exam Date _____ / _____ / _____
(no office stamps accepted without provider's signature)

4.) Examiner's Name _____

Street Address or P.O. _____

City/Town _____ State _____ ZIP _____ Phone # _____ - _____ - _____

A COPY OF THIS APPLICATION MUST BE FILED AT THE SOMA HEADQUARTERS & THE SECTION OFFICE

Last Name, First Name:

Form Expiration Date