

BASIC INFORMATION

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

Name _____

Social Security Number _____ Male Female Date of Birth _____/_____/_____ Home Phone # _____-_____-_____

Street Address or PO Box _____ Apt # _____

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

Email Address – Athlete or Family (circle one) _____

Parent/Guardian's Name _____ Home Phone # _____-_____-_____

Emergency Contact (if other than parent/guardian) _____ Emergency Contact Cell Phone # _____-_____-_____

Last Name, First Name:

HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER

Health/Accident Insurance Company _____ Policy # _____

<table border="0"> <tr> <td style="width: 50px;">Yes</td> <td style="width: 50px;">No</td> <td></td> <td style="width: 50px;">Yes</td> <td style="width: 50px;">No</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Heart disease / heart defect / high blood pressure</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Allergy:</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Chest pain</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td> General: _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Seizures / epilepsy/ fainting spells</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td> Medicines: _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Diabetes</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td> Food: _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Concussion or serious head injury</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td> Insect stings/bites: _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Major surgery or serious illness</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td> Special diet: _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Heat stroke / exhaustion</td> <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>Blindness / visual problem</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td> Emotional/psychiatric/behavioral/requires extra supervision</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Contact lenses / glasses</td> <td></td> <td></td> <td> Description: _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hearing loss / hearing aid</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td> Immunizations up to date</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Bone or joint problem</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td> Other: _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Currently on Medication (If yes, please bring current list with you to each competition)</td> <td></td> <td></td> <td>(For additional space, use back of form)</td> </tr> </table>	Yes	No		Yes	No		<input type="checkbox"/>	<input type="checkbox"/>	Heart disease / heart defect / high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Allergy:	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	General: _____	<input type="checkbox"/>	<input type="checkbox"/>	Seizures / epilepsy/ fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	Medicines: _____	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Food: _____	<input type="checkbox"/>	<input type="checkbox"/>	Concussion or serious head injury	<input type="checkbox"/>	<input type="checkbox"/>	Insect stings/bites: _____	<input type="checkbox"/>	<input type="checkbox"/>	Major surgery or serious illness	<input type="checkbox"/>	<input type="checkbox"/>	Special diet: _____	<input type="checkbox"/>	<input type="checkbox"/>	Heat stroke / exhaustion	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Blindness / visual problem	<input type="checkbox"/>	<input type="checkbox"/>	Emotional/psychiatric/behavioral/requires extra supervision	<input type="checkbox"/>	<input type="checkbox"/>	Contact lenses / glasses			Description: _____	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss / hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	Immunizations up to date	<input type="checkbox"/>	<input type="checkbox"/>	Bone or joint problem	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	Currently on Medication (If yes, please bring current list with you to each competition)			(For additional space, use back of form)	<p>Date of most recent tetanus immunization ____/____/____</p>
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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 Athletes 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 to treatment, that SOMA is authorized to take whatever measures are necessary to protect my health and well-being including hospitalization.

Signature of parent/caregiver/adult athlete (over 18): _____ Date: ____/____/____

Form Expiration Date

ATLANTO-AXIAL INSTABILITY ASSESSMENT FOR ATHLETES WITH DOWN SYNDROME

EXAMINER'S NOTE: SOMA requires persons with Down syndrome to have 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.

Yes No

Has an x-ray evaluation for atlanto-axial instability been done? Date of x-ray: ____/____/____

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

PHYSICAL EXAMINATION: TO BE COMPLETED BY HEALTHY CARE PROVIDER

Primary MR Etiology/Category: (If known) _____

I have reviewed the above health information and have performed the above examination on this athlete and certify that the athlete can participate in Special Olympics.

RESTRICTIONS: _____

EXAMINER'S SIGNATURE: _____ **Exam Date** ____/____/____

(no office stamps accepted without provider's signature)

Examiner's Name _____

Street Address or P.O. _____

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

A COPY OF THIS APPLICATION MUST BE WITH YOUR COACH AT ALL TRAININGS AND COMPETITIONS AND FILED AT THE SOMA HEADQUARTERS & SECTION OFFICE