

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 # _____-_____-_____

HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER

Health/Accident Insurance Company _____ Policy # _____

<table border="0"> <tr><th>Yes</th><th>No</th><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Heart disease / heart defect / high blood pressure</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Chest pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Seizures / epilepsy/ fainting spells</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Diabetes</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Concussion or serious head injury</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Major surgery or serious illness</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Heat stroke / exhaustion</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Blindness / visual problem</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Contact lenses / glasses</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hearing loss / hearing aid</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Bone or joint problem</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Currently on Medication (If yes, bring current list with you to competitions)</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Down Syndrome (If yes, answer questions below)</td></tr> </table>	Yes	No		<input type="checkbox"/>	<input type="checkbox"/>	Heart disease / heart defect / high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Seizures / epilepsy/ fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Concussion or serious head injury	<input type="checkbox"/>	<input type="checkbox"/>	Major surgery or serious illness	<input type="checkbox"/>	<input type="checkbox"/>	Heat stroke / exhaustion	<input type="checkbox"/>	<input type="checkbox"/>	Blindness / visual problem	<input type="checkbox"/>	<input type="checkbox"/>	Contact lenses / glasses	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss / hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	Bone or joint problem	<input type="checkbox"/>	<input type="checkbox"/>	Currently on Medication (If yes, bring current list with you to competitions)	<input type="checkbox"/>	<input type="checkbox"/>	Down Syndrome (If yes, answer questions below)	<table border="0"> <tr><th>Yes</th><th>No</th><td></td></tr> <tr><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> General: _____</td></tr> <tr><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> Food: _____</td></tr> <tr><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> Special diet: _____</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>Emotional/psychiatric/behavioral/requires extra supervision</td></tr> <tr><td></td><td></td><td> Description: _____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Immunizations up to date</td></tr> <tr><td></td><td></td><td> Date of most recent tetanus immunization ____/____/____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Other:</td></tr> </table>	Yes	No		<input type="checkbox"/>	<input type="checkbox"/>	Allergy:	<input type="checkbox"/>	<input type="checkbox"/>	General: _____	<input type="checkbox"/>	<input type="checkbox"/>	Medicines: _____	<input type="checkbox"/>	<input type="checkbox"/>	Food: _____	<input type="checkbox"/>	<input type="checkbox"/>	Insect stings/bites: _____	<input type="checkbox"/>	<input type="checkbox"/>	Special diet: _____	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Emotional/psychiatric/behavioral/requires extra supervision			Description: _____	<input type="checkbox"/>	<input type="checkbox"/>	Immunizations up to date			Date of most recent tetanus immunization ____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	Other:
Yes	No																																																																																	
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease / heart defect / high blood pressure																																																																																
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain																																																																																
<input type="checkbox"/>	<input type="checkbox"/>	Seizures / epilepsy/ fainting spells																																																																																
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes																																																																																
<input type="checkbox"/>	<input type="checkbox"/>	Concussion or serious head injury																																																																																
<input type="checkbox"/>	<input type="checkbox"/>	Major surgery or serious illness																																																																																
<input type="checkbox"/>	<input type="checkbox"/>	Heat stroke / exhaustion																																																																																
<input type="checkbox"/>	<input type="checkbox"/>	Blindness / visual problem																																																																																
<input type="checkbox"/>	<input type="checkbox"/>	Contact lenses / glasses																																																																																
<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss / hearing aid																																																																																
<input type="checkbox"/>	<input type="checkbox"/>	Bone or joint problem																																																																																
<input type="checkbox"/>	<input type="checkbox"/>	Currently on Medication (If yes, bring current list with you to competitions)																																																																																
<input type="checkbox"/>	<input type="checkbox"/>	Down Syndrome (If yes, answer questions below)																																																																																
Yes	No																																																																																	
<input type="checkbox"/>	<input type="checkbox"/>	Allergy:																																																																																
<input type="checkbox"/>	<input type="checkbox"/>	General: _____																																																																																
<input type="checkbox"/>	<input type="checkbox"/>	Medicines: _____																																																																																
<input type="checkbox"/>	<input type="checkbox"/>	Food: _____																																																																																
<input type="checkbox"/>	<input type="checkbox"/>	Insect stings/bites: _____																																																																																
<input type="checkbox"/>	<input type="checkbox"/>	Special diet: _____																																																																																
<input type="checkbox"/>	<input type="checkbox"/>	Asthma																																																																																
<input type="checkbox"/>	<input type="checkbox"/>	Emotional/psychiatric/behavioral/requires extra supervision																																																																																
		Description: _____																																																																																
<input type="checkbox"/>	<input type="checkbox"/>	Immunizations up to date																																																																																
		Date of most recent tetanus immunization ____/____/____																																																																																
<input type="checkbox"/>	<input type="checkbox"/>	Other:																																																																																

(For additional space, use back of form)

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:** ____/____/____

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 # _____-_____-_____