Special Olympics Wyoming
Be a fan..

232 East 2nd Street, Suite 201
Casper, WY 82601
(307) 235-3062 telephone
(307) 235-3063 fax
www.specialolympicswy.org

APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS WYOMING

(Medical Form for individuals with intellectual disabilities)

Please print clearly and complete ALL sections in their entirety

This application expires three (3) years from the date of the physical exam

DEMOGRAPHICS

Local Program _____ Application: (circle one) **NEW** **RENEWAL**

Athlete Information:

Last Name:_____ First Name:_____

Gender: Male_____ Female_____ Date of Birth: _____/_____/_____ (Month / Day / Year)

Street Address:_____

City:_____ State:_____ Zip:_____

Primary Phone:_____

Alternate Phone:_____

Email Address:_____

☐ Add email address to SOWY Newsletter mailing list

Parent/Guardian Information:

Name:_____

Street Address (if different than Athlete):

_____

City:_____State:_____Zip:_____

Primary Phone:_____

Alternate Phone:_____

Email Address:_____

☐ Add email address to SOWY Newsletter mailing list

Emergency Contact (if other than parent/guardian):_____ **Phone:**_____

Health/Accident Insurance Company:_____ **Policy Number**:_____

HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER

Yes	No		Yes	No		Yes	No	
☐	☐	Heart Problem/High Blood Pressure	☐	☐	Blindness/Impaired Vision	☐	☐	Emotional/Psychiatric/Behavioral
☐	☐	Chest Pain	☐	☐	Contact Lenses/Glasses	☐	☐	Sickle Cell Trait or Disease
☐	☐	Seizures/Epilepsy/Fainting Spells	☐	☐	Hearing Loss/Hearing Aid	☐	☐	Uses a Wheelchair
☐	☐	Diabetes	☐	☐	Bone or Joint Problem	☐	☐	Immunizations Up to Date
☐	☐	Concussion or Serious Head Injury	☐	☐	Asthma (exercise induced wheezing)	☐	☐	Tendency to Bleed Easily
☐	☐	Major Surgery or Serious Illness _____	☐	☐	Tobacco Use	☐	☐	Heat Stroke/Exhaustion

Allergies (list specific): Food_____ Medication_____ General/Insect sting/bites_____

Special Diet_____ Date of last tetanus immunization: ____/____/_____ Other:_____

Medications: Is the athlete taking any prescription medications? Yes ☐ No ☐ If yes, please list all medications below.

Please print medication name, amount, date prescribed and number of times per day medication is given. (Use separate sheet for additional space).

Medication Name	Dosage	Date Prescribed	Times Per Day	Medication Name	Dosage	Date Prescribed	Times Per Day

SIGNATURE OF PERSON COMPLETING THIS FORM (PARENT/GUARDIAN/ADULT ATHLETE): _____

ALSO PRINT NAME:_____ **DATE:** _____/_____/_____

ATLANTO-AXIAL INSTABILITY ASSESSMENT FOR ATHLETES WITH DOWN SYNDROME

PHYSICIAN'S NOTE: If the athlete has Down syndrome, Special Olympics requires a full radiological examination establishing the absence of Atlanto-axial Instability and the completion of the Special Examination Form before he/she may participate in sports or events which, by their nature, may result in hyper-extension, radical flexion or direct pressure on the neck or upper spine.

YES	NO	
☐	☐	Does the athlete have Down Syndrome
☐	☐	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)

*The sports and events for which such a radiological examination is required are: Judo, Equestrian sports, Gymnastics, Diving, Pentathlon, Butterfly stroke and Diving Starts in Swimming, High Jump, Alpine Skiing, Snowboarding, Squat Lift, and Football Team Competition (Soccer).

PHYSICAL EXAMINATION

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

Normal	Abnormal		Normal	Abnormal		Normal	Abnormal		Normal	Abnormal	
☐	☐	Vision	☐	☐	Extremities	☐	☐	Gastrointestinal System	☐	☐	Cranial Nerves
☐	☐	Hearing	☐	☐	Cardiovascular System	☐	☐	Genitourinary System	☐	☐	Coordination
☐	☐	Oral Cavity	☐	☐	Respiratory System	☐	☐	Skin	☐	☐	Reflexes
☐	☐	Neck	Other:_____								

I have reviewed the above health information and have performed the above examination on this athlete within the past 6 months and certify that the athlete can participate in Special Olympics.

SPORTS RESTRICTIONS:_____

EXAMINERS SIGNATURE:_____ **DATE:**_____/_____/_____ (MONTH / DAY / YEAR)

Print Examiners Name:_____ Certification: ☐ MD ☐ DO ☐ DC ☐ PA ☐ ARNP

Address: _____

City:_____ State:_____ Zip:_____ Phone:_____

SOWY use only

New Athlete
Recorded in GMS (date: _____)
Initial:_____

IMPORTANT: The following should keep copies of this form: 1) The State Office 2) The Local Program 3) The Head Coach 4)Athlete's Parent/Legal Guardian
All coaches will be responsible for having up-to-date athlete medical forms in their possession at training and competition events and during transportation and travel.