APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS CONNECTICUT

LOCAL PROGRAM:		**PLEASE CHECK _______NEW _____RENEWAL**
Name (First – Last):		
Date of birth: _________/_________/_________	Gender ____Male ____Female	Phone: ( )
Street:		
City:	State:	ZIP Code:

PARENT OR GUARDIAN INFORMATION		
Name		
Address (if different than athlete's)		
City	State:	ZIP Code:
Phone Home:	Work:	Mobile:
E-Mail		

EMERGENCY CONTACT IF DIFFERENT THAN PARENT OR GUARDIAN	
Name:	Phone:

HEALTH HISTORY

AN UP TO DATE HEALTH HISTORY AND A PHYSICAL EXAMINATION PERFORMED BY A LICENSED PHYSICIAN IS REQUIRED UPON ENTRY INTO THE PROGRAM. A PHYSICAL EXAMINATION IS REQUIRED EVERY 3 YEARS FOR ATHLETES WITH "YES" RESPONSES TO ITEMS 1 -5. A PHYSICAL EXAMINATION IS REQUIRED FOR ALL ATHLETES WITH A "NEW PROBLEM" RESPONSE TO ITEMS 7-11. ATHLETES MUST SUBMIT THIS FORM EVERY 3 YEARS WHETHER OR NOT AN EXAMINATION IS NECESSARY.

1. HEART PROBLEMS ____YES ____NO	9. SURGERY OR ILLNESS ___YES ___NO ___NEW	17. EMOTIONAL/BEHAVIOR PROBLEMS ____YES ____NO
2. CHEST PAINS ____YES ____NO	10.HEAT STROKE/COLD ILLNESS ___YES ___NO ___NEW	18. BONE OR JOINT DISORDER ____YES ____NO
3. SEIZURES/EPILEPSY ____YES ____NO	11. OTHER PROBLEM (S) THAT WOULD INTERFERE	19. SICKLE CELL/TRAIT DISEASE ____YES ____NO
4. DIABETES ____YES ____NO	WITH SPORTS PARTICIPATION ____YES ___NO ___NEW	20. HEARING LOSS/ HEARING AID ____YES ____NO
5. DOWN SYNDROME ____YES ____NO	LIST: ____	21. CONTACTS/EYEGLASSES ____YES ____NO
NECK X-RAY DONE ____YES ____NO	12. IMPAIRED MOBILITY _____YES ____NO	22. DENTURES/FALSE TEETH ____YES ____NO
INSTABILITY PRESENT ____YES ____NO	13. USES A WHEELCHAIR _____YES ____NO	23. DATE OF LAST TETANUS SHOT ______/______/____
6. BLINDNESS/VISION PROBLEM ____YES ____NO __NEW	14. SPECIAL DIET _____YES _____NO	24. LIST ALLERGY TO: INSECT STING ___YES ____NO
7. ABSENCE OF KIDNEY/TESTICLE ____YES ___NO ___NEW	15. ASTHMA _____YES _____NO	MEDICINE________________________ ___YES ____NO
8. HEAD INJURY/CONCUSSION ____YES ___NO ___NEW	16. BLEEDING PROBLEMS _____YES ____NO	FOODS__________________________ ___YES ____NO

ADDITIONAL COMMENTS:

MEDICATIONS: PLEASE PRINT MEDICATION NAME, AMOUNT AND NUMBER OF TIMES PER DAY MEDICATION NEEDS TO BE TAKEN:

SIGNATURES

EXAMINERS NOTE: If an athlete has Down Syndrome, Special Olympics requires 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. The sports and events for which such a radiological examination is required are equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, squat lift and football team competition (soccer).

RESTRICTIONS:	DATE: __________/_________/_________
EXAMINERS SIGNATURE:	DATE: __________/________/__________
EXAMINERS NAME:	PHONE: ( )
APPLICANT OR PARENT/GUARDIAN SIGNATURE:	DATE: _________/________/__________

THIS FORM MUST BE COMPLETED LEGIBLY, SIGNED AND DATED TO BE CONSIDERED VALID.