

PARTICIPANT RELEASE FORM

Special Olympics
Georgia



I want to take part in Special Olympics and agree to the following:

1. **Able to Participate.** I am able to take part in Special Olympics. I know there is a risk of injury.
2. **Photo Release.** Special Olympics organizations may use my picture, video, name, voice, and words to promote Special Olympics.
3. **Overnight Stay.** For some events, I may stay in a hotel, college dorm or someone's home. If I have questions, I will ask.

SOGA Housing Policy – Special Olympics Georgia (SOGA) usually provides housing for Athletes, Unified Partners and Coaches entered in each State Games. SOGA totals the number of male and female Athletes, Unified Partners and Coaches per agency and assigns room allotments based on those totals. When determining allotted room numbers, SOGA allocates and provides 4 persons of the same gender per room for a Double/Double or King room with a pullout, 2 persons of the same gender per room for a King room and 5 persons of the same gender per room for a Queen/Queen with a pullout. In dorm rooms, SOGA allots one bed per person. Athletes, Unified Partners, Coaches and general volunteers may not share a room with Athletes, Unified Partners, Coaches and general volunteers of the opposite sex.

4. **Emergency Care.** I consent to medical care if needed in an emergency, unless I check one of these boxes:

- I have a religious or other objection to receiving medical treatment.
- I do not consent to blood transfusions.

(If either box is checked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)

5. **Health Programs.** If I take part in a health program, I consent to health activities, exams, and treatment. This should not replace regular health care. I can say no to treatment or anything else any time.
6. **Personal Information.** I understand my information may be used and shared by Special Olympics to: Make sure I am eligible and can participate safely; Run trainings and events and share results; Put my information in a computer system; Provide health treatment, make referrals, consult doctors, and remind me about follow-up services; Research, share, and respond to needs of Special Olympics participants (identifying information removed if shared publicly); and Protect health and safety, respond to government requests, and report information required by law. I can ask to see and revise my information. I can ask to limit how my information is used.
7. **Concussions.** I understand the risk of concussions and continuing to play sports with a concussion. I may have to get medical care if I have a suspected concussion. I also may have to wait 7 days or more and get permission from a doctor before I start playing sports again.
8. **Communicable Disease(s).** Participation includes possible exposure to and illness from infectious and/or communicable diseases including but not limited to MRSA, influenza, and COVID-19. While particular rules and personal discipline may reduce this risk, the risk of serious illness and death does exist; and, I KNOWINGLY AND FREELY ASSUME ALL SUCH RISKS, both known and unknown, EVEN IF ARISING FROM THE NEGLIGENCE OF THE RELEASEES or others, and assume full responsibility for my participation; and, I willingly agree to comply with the stated and customary terms and conditions for participation as regards protection against infectious diseases. If, however, I observe and any unusual or significant hazard during my presence or participation, I will remove myself from participation and bring such to the attention of the nearest official immediately; and, I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, HEREBY RELEASE AND HOLD HARMLESS Special Olympics, Inc, Special Olympics Georgia their officers, officials, agents, and/or employees, other participants, sponsoring agencies, sponsors, advertisers, and if applicable, owners and lessors of premises used to conduct the event ("RELEASEES"), WITH RESPECT TO ANY AND ALL ILLNESS, DISABILITY, DEATH, or loss or damage to person or property, WHETHER ARISING FROM THE NEGLIGENCE OF RELEASEES OR OTHERWISE, to the fullest extent permitted by law.

PARTICIPANT NAME (PRINT): _____

PARTICIPANT SIGNATURE (required if over 18 years old and signing on own behalf)

I have read and understand this release. If I have questions, I will ask. By signing, I agree to this form.

Participant Signature: _____ Date: _____

PARENT/GUARDIAN SIGNATURE (required if under 18 years old or has a legal guardian)

I am a parent or guardian of the Participant. I have read and understand this form and have explained the contents to the Participant as appropriate. By signing, I agree to this form on my own behalf and on behalf of the Participant.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

(You cannot alter this form under any circumstances)

Athlete Medical Form – HEALTH HISTORY

(pages 1 & 2 to be completed by the athlete or parent/guardian/caregiver)
Must Complete ALL Items on these two pages



AREA & AGENCY:

ATHLETE INFORMATION

Female: Male: Other Gender Identity:

First Name: Middle Name:

Last Name:

Date Birth (mm/dd/yyyy):

Address (Street):

Address (City, State, Zip):

Phone: Cell:

E-mail:

Athlete Employer, if any:

Eye color: I am my own guardian. Yes No

Race/Ethnicity:

- American Indian/Alaskan Asian American
 Black or African Native Hawaiian or Other Pacific
 White or Caucasian Hispanic or Latinx
 Prefer not to answer More than one race

Does the athlete have (check any that apply):

- Fragile X Syndrome Down syndrome
 Autism Fetal Alcohol Syndrome
 Cerebral Palsy
Other syndrome, please specify:

Is the athlete allergic to any of the following (please list):

- Latex No Known Allergies
 Medications:
 Insect Bites or Stings:
 Food:

List any special dietary needs:

List all past surgeries:

PARENT GUARDIAN INFORMATION (if not own guardian)

Name:

Phone: Cell:

E-mail:

Emergency Contact Name: Same as Above:

Emergency Contact Phone (cell):

Emergency Contact Relationship:

Does the athlete have a primary care physician? Yes No *If yes, list.*

Physician Name: Physician Phone:

Insurance Policy (Company and Number):

Does the athlete have any objections to emergency medical care?
 No Yes *If yes, contact your local Program to get the Emergency Care Refusal Form.*

LIST ANY SPORTS THE ATHLETE WISHES TO PLAY:

Has a doctor ever limited the athlete's participation in sports?

No Yes *If yes, please describe:*

Has the athlete ever had an abnormal Electrocardiogram (EKG) or Echocardiogram (Echo)? *If yes, select below and describe.*

Yes, had abnormal EKG Yes, had abnormal Echo

Does the athlete currently have any chronic or acute infection?

No Yes *If yes, please describe:*

Does the athlete use: (check any that apply):

- Brace Colostomy Communication Device
 C-PAP Machine Crutches or Walker Dentures
 Glasses or Contacts G-Tube or J-Tube Hearing Aid
 Implanted Device Inhaler Pacemaker
 Removable Prosthetics Splint Wheel Chair

Has the athlete had a Tetanus vaccine in the past 7 years? No Yes

FAMILY HISTORY

Has any relative died of a heart problem before age 50? No Yes

Has any family member or relative died while exercising? No Yes

List all medical conditions that run in the athlete's family:

Athlete Medical Form – HEALTH HISTORY

(pages 1 & 2 to be completed by athlete or parent/guardian/caregiver)



Athlete's Name:

HAS THE ATHLETE EVER BEEN DIAGNOSED WITH OR EXPERIENCED ANY OF THE FOLLOWING CONDITIONS

- | | | | | | |
|--|--|---------------------|--|--------------------|--|
| Loss of Consciousness | <input type="checkbox"/> No <input type="checkbox"/> Yes | High Blood Pressure | <input type="checkbox"/> No <input type="checkbox"/> Yes | Stroke/TIA | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Dizziness during or after exercise | <input type="checkbox"/> No <input type="checkbox"/> Yes | High Cholesterol | <input type="checkbox"/> No <input type="checkbox"/> Yes | Concussions | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Headache during or after exercise | <input type="checkbox"/> No <input type="checkbox"/> Yes | Vision Impairment | <input type="checkbox"/> No <input type="checkbox"/> Yes | Asthma | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Chest pain during or after exercise | <input type="checkbox"/> No <input type="checkbox"/> Yes | Hearing Impairment | <input type="checkbox"/> No <input type="checkbox"/> Yes | Diabetes | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Shortness of breath during or after exercise | <input type="checkbox"/> No <input type="checkbox"/> Yes | Enlarged Spleen | <input type="checkbox"/> No <input type="checkbox"/> Yes | Hepatitis | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Irregular, racing or skipped heart beats | <input type="checkbox"/> No <input type="checkbox"/> Yes | Single Kidney | <input type="checkbox"/> No <input type="checkbox"/> Yes | Urinary Discomfort | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Congenital Heart Defect | <input type="checkbox"/> No <input type="checkbox"/> Yes | Osteoporosis | <input type="checkbox"/> No <input type="checkbox"/> Yes | Spina Bifida | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Heart Attack | <input type="checkbox"/> No <input type="checkbox"/> Yes | Osteopenia | <input type="checkbox"/> No <input type="checkbox"/> Yes | Arthritis | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Cardiomyopathy | <input type="checkbox"/> No <input type="checkbox"/> Yes | Sickle Cell Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes | Heat Illness | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Heart Valve Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes | Sickle Cell Trait | <input type="checkbox"/> No <input type="checkbox"/> Yes | Broken Bones | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Heart Murmur | <input type="checkbox"/> No <input type="checkbox"/> Yes | Easy Bleeding | <input type="checkbox"/> No <input type="checkbox"/> Yes | Dislocated Joints | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Endocarditis | <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | |

Difficulty controlling bowels or bladder No Yes
 If yes, is this new or worse in the past 3 years? No Yes

Numbness or tingling in legs, arms, hands or feet No Yes
 If yes, is this new or worse in the past 3 years? No Yes

Weakness in legs, arms, hands or feet No Yes
 If yes, is this new or worse in the past 3 years? No Yes

Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet No Yes
 If yes, is this new or worse in the past 3 years? No Yes

Head Tilt No Yes
 If yes, is this new or worse in the past 3 years? No Yes

Spasticity No Yes
 If yes, is this new or worse in the past 3 years? No Yes

Paralysis No Yes
 If yes, is this new or worse in the past 3 years? No Yes

Describe any past broken bones or dislocated joints (if yes is checked for either of those fields above):

Epilepsy or any type of seizure disorder No Yes
 If yes, list seizure type:

If yes, had seizure during the past year? No Yes

Self-injurious behavior during the past year No Yes

Aggressive behavior during the past year No Yes

Depression (diagnosed) No Yes

Anxiety (diagnosed) No Yes

Describe any additional mental health concerns:

List any other ongoing or past medical conditions:

PLEASE LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW (includes inhalers, birth control or hormone therapy)

Medication, Vitamin or Supplement	Dosage	Times per Day	Medication, Vitamin or Supplement	Dosage	Times per Day	Medication, Vitamin or Supplement	Dosage	Times per Day

Is the athlete able to administer his or her own medications? No Yes

If female athlete, list date of last menstrual period:

Name of Person Completing this Form	Relationship to Athlete	Phone	Email
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Athlete Medical Form – PHYSICAL EXAM

(to be completed by a Medical Professional only)

Special
Olympics
Georgia



Athlete's Name:

MEDICAL PHYSICAL INFORMATION (TO BE COMPLETED BY EXAMINER ONLY)

Height	Weight	BMI (optional)	Temperature	Pulse	O2Sat	Blood Pressure		Vision
<input type="text"/> cm	<input type="text"/> kg	<input type="text"/> BMI	<input type="text"/> C	<input type="text"/>	<input type="text"/>	BP Right	BP Left	Right Vision 20/40 or better
<input type="text"/> in	<input type="text"/> lbs	<input type="text"/> Body Fat %	<input type="text"/> F					Left Vision 20/40 or better
Right Hearing (Finger Rub)	<input type="checkbox"/> Responds	<input type="checkbox"/> No Response	<input type="checkbox"/> Can't Evaluate	Bowel Sounds	<input type="checkbox"/> No	<input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A
Left Hearing (Finger Rub)	<input type="checkbox"/> Responds	<input type="checkbox"/> No Response	<input type="checkbox"/> Can't Evaluate	Hepatomegaly	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Right Ear Canal	<input type="checkbox"/> Clear	<input type="checkbox"/> Cerumen	<input type="checkbox"/> Foreign Body	Splenomegaly	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
Left Ear Canal	<input type="checkbox"/> Clear	<input type="checkbox"/> Cerumen	<input type="checkbox"/> Foreign Body	Abdominal Tenderness	<input type="checkbox"/> No	<input type="checkbox"/> RUQ <input type="checkbox"/> RLQ <input type="checkbox"/> LUQ <input type="checkbox"/> LLQ		
Right Tympanic Membrane	<input type="checkbox"/> Clear	<input type="checkbox"/> Perforation	<input type="checkbox"/> Infection <input type="checkbox"/> NA	Kidney Tenderness	<input type="checkbox"/> No	<input type="checkbox"/> Right <input type="checkbox"/> Left		
Left Tympanic Membrane	<input type="checkbox"/> Clear	<input type="checkbox"/> Perforation	<input type="checkbox"/> Infection <input type="checkbox"/> NA	Right upper extremity reflex	<input type="checkbox"/> Normal	<input type="checkbox"/> Diminished <input type="checkbox"/> Hyperreflexia		
Oral Hygiene	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	Left upper extremity reflex	<input type="checkbox"/> Normal	<input type="checkbox"/> Diminished <input type="checkbox"/> Hyperreflexia		
Thyroid Enlargement	<input type="checkbox"/> No	<input type="checkbox"/> Yes		Right lower extremity reflex	<input type="checkbox"/> Normal	<input type="checkbox"/> Diminished <input type="checkbox"/> Hyperreflexia		
Lymph Node Enlargement	<input type="checkbox"/> No	<input type="checkbox"/> Yes		Left lower extremity reflex	<input type="checkbox"/> Normal	<input type="checkbox"/> Diminished <input type="checkbox"/> Hyperreflexia		
Heart Murmur (supine)	<input type="checkbox"/> No	<input type="checkbox"/> 1/6 or 2/6	<input type="checkbox"/> 3/6 or greater	Abnormal Gait	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe below		
Heart Murmur (upright)	<input type="checkbox"/> No	<input type="checkbox"/> 1/6 or 2/6	<input type="checkbox"/> 3/6 or greater	Spasticity	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe below		
Heart Rhythm	<input type="checkbox"/> Regular	<input type="checkbox"/> Irregular		Tremor	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe below		
Lungs	<input type="checkbox"/> Clear	<input type="checkbox"/> Not clear		Neck & Back Mobility	<input type="checkbox"/> Full	<input type="checkbox"/> Not full, describe below		
Right Leg Edema	<input type="checkbox"/> No	<input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+		Upper Extremity Mobility	<input type="checkbox"/> Full	<input type="checkbox"/> Not full, describe below		
Left Leg Edema	<input type="checkbox"/> No	<input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+ Radial		Lower Extremity Mobility	<input type="checkbox"/> Full	<input type="checkbox"/> Not full, describe below		
Pulse Symmetry	<input type="checkbox"/> Yes	<input type="checkbox"/> R>L <input type="checkbox"/> L>R		Upper Extremity Strength	<input type="checkbox"/> Full	<input type="checkbox"/> Not full, describe below		
Cyanosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe		Lower Extremity Strength	<input type="checkbox"/> Full	<input type="checkbox"/> Not full, describe below		
Clubbing	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe		Loss of Sensitivity	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe below		

ATLANTO-AXIAL INSTABILITY (AAI)

- Athlete shows **NO EVIDENCE** of neurological symptoms or physical findings associated with spinal cord compression or atlantoaxial instability.
- Athlete has neurological symptoms or physical findings that could be associated with spinal cord compression or atlantoaxial instability and **must receive an additional neurological evaluation** to rule out additional risk of spinal cord injury prior to clearance for sports participation.

RECOMMENDATIONS (TO BE COMPLETED BY EXAMINER ONLY)

Licensed Medical Examiners: It is recommended that the examiner review items on the medical history with the athlete or their guardian, prior to performing the physical exam. If an athlete needs further medical evaluation please use the Special Olympics Further Medical Evaluation Form, page 4, to provide the athlete with medical clearance..

This athlete is **ABLE** to participate in Special Olympics sports without restrictions/limitations

This athlete is **ABLE** to participate in Special Olympics sports **WITH** restrictions/limitations →

This athlete **MAY NOT** participate in Special Olympics sports at this time and **MUST** be further evaluated by a physician for the following concerns:

- | | | |
|------------------------------|---|--|
| Concerning Cardiac Exam | <input type="checkbox"/> Acute Infection | <input type="checkbox"/> O ₂ Saturation Less than 90% on Room Air |
| Concerning Neurological Exam | <input type="checkbox"/> Stage II Hypertension or Greater | <input type="checkbox"/> Hepatomegaly or Splenomegaly |

Other, please describe:

Additional Licensed Examiner's Notes and Recommended Follow-up:

- | | | |
|---|--|---|
| <input type="checkbox"/> Follow up with a cardiologist | <input type="checkbox"/> Follow up with a neurologist | <input type="checkbox"/> Follow up with a primary care physician |
| <input type="checkbox"/> Follow up with a vision specialist | <input type="checkbox"/> Follow up with a hearing specialist | <input type="checkbox"/> Follow up with a dentist or dental hygienist |
| <input type="checkbox"/> Follow up with a podiatrist | <input type="checkbox"/> Follow up with a physical therapist | <input type="checkbox"/> Follow up with a nutritionist |

Other/Exam Notes:

Licensed Medical Examiner's Signature

Date of Exam

Name: _____

E-mail: _____

Phone: _____

License: _____