

## 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