

370 George Washington Highway Smithfield, RI 02917 (401) 349-4900 telephone (401) 349-4936 fax www.specialolympicsri.org

## APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS RHODE ISLAND

(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:						Parent/Guardian Information:			
Last Name:First Name:						Name:			
Gender: Male FemaleDate of Birth:/_						Relation:			
Street Address:			Month	Day	Year	Street Addre	SS (if different than At	hlete):	
City:			Zip:			City	Stata	7in.	
Primary Phone:						•		Zip:	
Alternate Phone:									
Email Address:									
Add email address to SORI Newsletter mailing list							SS:		
Emergency Contact (if other than parent/guardian): Phone:									
Health/Accident Insurance Company: Policy Number:									
HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER/ADULT ATHLETE									
Yes No  ☐ Heart Problem/High Blood Pressure ☐ Chest Pain ☐ Seizures/Epilepsy/Fainting Spells ☐ Diabetes ☐ Concussion or Serious Head Injury ☐ Major Surgery or Serious Illness			Yes No  Blindness/Impaired Vision  Contact Lenses/Glasses  Hearing Loss/Hearing Aid  Bone or Joint Problem  Asthma (exercise induced whee			Yes No    Emotional/Psychiatric/Behavioral   Sickle Cell Trait or Disease   Uses a Wheelchair   Immunizations Up to Date   ezing)			
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	ledication Name   Dosage   Date Prescribed		Times Per	Day	Medication Name	Dosage	Date Prescribed	Times Per Day	
SIGNATURE OF REDSON COMPLETING THIS FORM (BARENT/CHARDIAN/ARIH T ATHLETE).									
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									
Normal Abnormal Normal Abnormal Normal Abnormal Abnormal Abnormal Abnormal Abnormal Normal Abnormal Normal Abnormal Normal Abnormal Abnormal Normal Abnormal Abnormal Normal Normal Abnormal Normal Abnormal Normal Abnormal Normal Abnormal Normal Abnormal Normal Normal Abnormal Normal Norma									
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: / /									
Print Examiners Name:Certification:									
Address:									
City:		State:	_ Zip:		Phone:				
SORI  Use only  Recorded in GMS (date:)  Initial:  New Athlete  IMPORTANT: This is a legal document. The following should keep copies of this form: 1) The State Office 2) The Head Coach 3)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.									