Special Olympics Maryland

# Welcome to Special Olympics Maryland!

We are excited to have you join us as a Special Olympics Maryland Athlete and look forward to seeing you succeed on and off the field of play! As a Special Olympics Maryland Athlete, you'll have the opportunity to train and compete in a variety of sports throughout the year; learning new skills, building confidence, and making life-long friendships. In addition to a wide variety of sports, we also offer an impactful Athlete Leadership program where you can develop skills in public speaking, leading teams, self-advocacy, and even good money habits!

But before you start participating in our many programs, you first need to register as a Special Olympics Maryland Athlete. **The Athlete Registration Packet**, included with this welcome letter contains the following items:

| | |
|---|---|
| 1. | Athlete Medical- Health History *(to be completed by the athlete or parent/guardian)* |
| 2. | Athlete Medical- Physical Exam & Medical Referral *(to be completed by a medical professional)* |
| 3. | Athlete Participation Waiver |
| 4. | Communicable Disease Waiver |

These items must be completed with necessary signatures and submitted through your **area program**! We can only accept full, completed packets. Use the link or QR Code below to connect with your area program. Once your completed registration packet is received and processed by your Area Program, you can start signing up for programs!

Scan this QR Code with your mobile device camera to connect with your Area Program

OR

Click this link to connect with your Area Program.

## It's time to get into the game! We're excited to have you on our team!

Special Olympics Maryland
3701 Commerce Drive, Suite 103, Baltimore, MD 21227
**Tel** 410-242-1515 **Fax** 410-242-2580 www.somd.org
*Created by the Joseph P. Kennedy Jr. Foundation for the benefit of persons with intellectual disabilities*

04/2024

# Athlete Medical Form – **HEALTH HISTORY**

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

Special Olympics Maryland

**REGION/AREA:**

**DELEGATION/TEAM:**

☐ New Athlete
☐ Re-Registering (Returning) Athlete

## ATHLETE INFORMATION

First Name: Middle Name:

Last Name:

Date Birth *(mm/dd/yyyy)* : Female: ☐ Male: ☐

Address (Street):

Address (City, State, Zip):

Phone: Cell:

E-mail:

Eye color: Ethnicity: *(optional)*

Athlete Employer, if any:

*I am my own guardian.* ☐ Yes ☐ No

**Does the athlete have** *(check any that apply)*:

☐ Autism ☐ Down syndrome ☐ Fragile X Syndrome
☐ Cerebral Palsy ☐ Fetal Alcohol Syndrome
☐ 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:**

**Does the athlete currently have any chronic or acute infection?**
☐ 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

## ☐ 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:*

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

# Athlete Medical Form – **PHYSICAL EXAM**
**(to be completed by a Medical Professional only)**

Special Olympics Maryland

**Athlete's Name:**

## MEDICAL PHYSICAL INFORMATION *(TO BE COMPLETED BY EXAMINER ONLY)*

| Height | Weight | BMI *(optional)* | Temperature | Pulse | $O_2$Sat | Blood Pressure | Vision |
|---|---|---|---|---|---|---|---|
| cm / in | kg / lbs | BMI / Body Fat % | C / F | | | BP Right: / BP Left: | Right Vision 20/40 or better ☐ No ☐ Yes ☐ N/A<br>Left Vision 20/40 or better ☐ No ☐ Yes ☐ N/A |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Right Hearing (Finger Rub) | ☐ Responds | ☐ No Response | ☐ Can't Evaluate | | Bowel Sounds | ☐ Yes | ☐ No |
| Left Hearing (Finger Rub) | ☐ Responds | ☐ No Response | ☐ Can't Evaluate | | Hepatomegaly | ☐ No | ☐ Yes |
| Right Ear Canal | ☐ Clear | ☐ Cerumen | ☐ Foreign Body | | Splenomegaly | ☐ No | ☐ Yes |
| Left Ear Canal | ☐ Clear | ☐ Cerumen | ☐ Foreign Body | | Abdominal Tenderness | ☐ No | ☐ RUQ ☐ RLQ ☐ LUQ ☐ LLQ |
| Right Tympanic Membrane | ☐ Clear | ☐ Perforation | ☐ Infection | ☐ NA | Kidney Tenderness | ☐ No | ☐ Right ☐ Left |
| Left Tympanic Membrane | ☐ Clear | ☐ Perforation | ☐ Infection | ☐ NA | Right upper extremity reflex | ☐ Normal | ☐ Diminished ☐ Hyperreflexia |
| Oral Hygiene | ☐ Good | ☐ Fair | ☐ Poor | | Left upper extremity reflex | ☐ Normal | ☐ Diminished ☐ Hyperreflexia |
| Thyroid Enlargement | ☐ No | ☐ Yes | | | Right lower extremity reflex | ☐ Normal | ☐ Diminished ☐ Hyperreflexia |
| Lymph Node Enlargement | ☐ No | ☐ Yes | | | Left lower extremity reflex | ☐ Normal | ☐ Diminished ☐ Hyperreflexia |
| Heart Murmur (supine) | ☐ No | ☐ 1/6 or 2/6 | ☐ 3/6 or greater | | Abnormal Gait | ☐ No | ☐ Yes, describe below |
| Heart Murmur (upright) | ☐ No | ☐ 1/6 or 2/6 | ☐ 3/6 or greater | | Spasticity | ☐ No | ☐ Yes, describe below |
| Heart Rhythm | ☐ Regular | ☐ Irregular | | | Tremor | ☐ No | ☐ Yes, describe below |
| Lungs | ☐ Clear | ☐ Not clear | | | Neck & Back Mobility | ☐ Full | ☐ Not full, describe below |
| Right Leg Edema | ☐ No | ☐ 1+ ☐ 2+ | ☐ 3+ ☐ 4+ | | Upper Extremity Mobility | ☐ Full | ☐ Not full, describe below |
| Left Leg Edema | ☐ No | ☐ 1+ ☐ 2+ | ☐ 3+ ☐ 4+ | | Lower Extremity Mobility | ☐ Full | ☐ Not full, describe below |
| Radial Pulse Symmetry | ☐ Yes | ☐ R>L | ☐ L>R | | Upper Extremity Strength | ☐ Full | ☐ Not full, describe below |
| Cyanosis | ☐ No | ☐ Yes, describe | | | Lower Extremity Strength | ☐ Full | ☐ Not full, describe below |
| Clubbing | ☐ No | ☐ Yes, describe | | | Loss of Sensitivity | ☐ No | ☐ 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 | ☐ Acute Infection | ☐ $O_2$ Saturation Less than 90% on Room Air |
| ☐ Concerning Neurological Exam | ☐ Stage II Hypertension or Greater | ☐ Hepatomegaly or Splenomegaly |
| ☐ Other, please describe: | | |

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

| | | |
|---|---|---|
| ☐ Follow up with a cardiologist | ☐ Follow up with a neurologist | ☐ Follow up with a primary care physician |
| ☐ Follow up with a vision specialist | ☐ Follow up with a hearing specialist | ☐ Follow up with a dentist or dental hygienist |
| ☐ Follow up with a podiatrist | ☐ Follow up with a physical therapist | ☐ Follow up with a nutritionist |

☐ Other/Exam Notes:

| | | | |
|---|---|---|---|
| | | Name: | |
| | | E-mail: | |
| Licensed Medical Examiner's Signature | Date of Exam | Phone: | License: |

# Athlete Medical Form – **MEDICAL REFERRAL FORM**

**(to be completed by a Medical Professional only if referral is needed)**

Special Olympics Maryland

**Athlete's Name:**

**This page only needs to be completed and signed if the physician on page three does not clear the athlete and indicates follow-up is required. Athlete should bring the previously completed pages to the appointment with the specialist.**

Examiner's Name:

Specialty:

I have examined this athlete for the following medical concern(s):
*Please describe*

**In my professional opinion, this athlete MAY participate in Special Olympics sports (indicate restrictions or limitations below):**

☐ **Yes, without restrictions** ☐ **Yes, but with restrictions** ***(list below)*** ☐ **No**

Additional Examiner Notes/Restrictions:

Examiner E-mail:

Examiner Phone:

License:

| | |
|---|---|
| **Examiner's Signature** | **Date** |

## This section to be completed by Special Olympics staff only, if applicable.

This medical exam was completed at a MedFest event? ☐ Yes ☐ No

The athlete is a Unified Partner or a Young Athlete Participant? ☐ Unified Partner ☐ Young Athlete

**ATHLETE PARTICIPATION WAIVER**

Special Olympics Maryland

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

1. **Able to Participate.** I am eligible and able to take part in Special Olympics activities. 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 without compensation to me, my family or representatives.

3. **Overnight Stay.** For some events, I may be required to stay overnight. I understand the health and safety of all Special Olympics Maryland participants is of paramount importance to Special Olympics Maryland. Athletes will be matched for housing based on size, level of maturity, ability and age. Each **member** of the delegation shall be assigned his/her own bed. Athletes and volunteers may not share a room with an athlete or volunteer of the opposite sex *. The chaperone/athlete ratio of at least one properly registered chaperone to every four athletes must be maintained during overnight events. All chaperones must be screened in accordance with the Special Olympics Volunteer Screening Policy. *See complete Special Olympics Maryland Housing Policy for allowed exceptions. The complete Special Olympics Maryland Housing Policy can be found at www.somd.org if I have questions, I will ask.

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 consent to emergency medical care, but 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 publically); 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. Go here for more Concussion information: https://www.cdc.gov/headsup/

**PARTICIPANT NAME:** _____ **AREA/COUNTY PARTICIPATING WITH**: _____

**PARTICIPANT SIGNATURE** (required if 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: _____

**WAIVER AND RELEASE OF LIABILITY, ASSUMPTION OF RISK AND INDEMNIFICATION AGREEMENT FOR COMMUNICABLE DISEASES**
**("Agreement") for**
**SPECIAL OLYMPICS**

In consideration of being allowed to participate in any way in Special Olympics sports training, competition or fundraising activities, the undersigned acknowledges, appreciates, and agrees that:

1. 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,
2. 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,
3. 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 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,
4. 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 Maryland, 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.

**I HAVE READ THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IF FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.**

Name of Participant: _____

Participant Signature: _____

Date signed: _____

**Parent/Guardian Signature (required if under 18 years old or has a legal guardian)**

This is to certify that I, as parent/guardian, with legal responsibility for this participant, have read and explained the provisions in this waiver/release to my child/ward including the risks of presence and participation and his/her personal responsibilities for adhering to the rules and regulations for protection against communicable diseases. Furthermore, my child/ward understands and accepts these risks and responsibilities. I for myself, my spouse, and child/ward do consent and agree to his/her release provided above for all the Releasees and myself, my spouse, and child/ward do release and agree to indemnify and hold harmless the Releasees for any and all liabilities incident to my minor child's/ward's presence or participation in these activities as provided above, EVEN IF ARISING FROM THEIR NEGLIGENCE, to the fullest extent provided by law.

Name of parent/guardian: _____

Parent guardian/signature: _____

Date signed: _____