

APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS NORTH DAKOTA

SECTION 1 DEMOGRAPHICS

Program _____ Male Female Date of Birth (m/d/y) ___/___/___
 Athlete's Name _____
 Athlete's Address _____ Home Phone # _____
 City _____ State _____ Zip _____
 Parent/Guardian's Name _____ Work Phone # _____
 Parent/Guardian's Address (if different than athlete) _____ Home Phone# _____
 City _____ State _____ Zip _____
 Emergency Contact (if different than parent/guardian) _____ Phone # _____
 Health/Accident Insurance Company _____ Policy # _____

SECTION 2 HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER

<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Disease/Heart Defect/Highblood Pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Chest Pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Seizures/Epilepsy/Fainting Spells</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> Concussion or Serious Head Injury</p> <p><input type="checkbox"/> <input type="checkbox"/> Major Surgery or Serious Illness</p> <p><input type="checkbox"/> <input type="checkbox"/> Heat Stroke/Exhaustion</p> <p><input type="checkbox"/> <input type="checkbox"/> Blindness/Visual Problems (other than corrective lenses)</p> <p><input type="checkbox"/> <input type="checkbox"/> Contact Lenses/Glasses</p> <p><input type="checkbox"/> <input type="checkbox"/> Hearing Loss/Hearing Aid</p> <p><input type="checkbox"/> <input type="checkbox"/> Bone or Joint Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Medicine Allergies: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Food Allergies: _____</p> <p>Date of most recent tetanus immunization: ___/___/___</p>	<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Sting/Bite Allergies: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> General Allergies: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Special Diet _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> Uses Tobacco</p> <p><input type="checkbox"/> <input type="checkbox"/> Easy Bleeding</p> <p><input type="checkbox"/> <input type="checkbox"/> Emotional/Psychiatric/Behavioral Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Shunts</p> <p><input type="checkbox"/> <input type="checkbox"/> Down Syndrome (if yes, complete section 3)</p> <p><input type="checkbox"/> <input type="checkbox"/> Uses Wheelchair</p> <p><input type="checkbox"/> <input type="checkbox"/> Non-verbal</p> <p><input type="checkbox"/> <input type="checkbox"/> Immunizations up-to-date</p> <p><input type="checkbox"/> <input type="checkbox"/> Other _____</p>
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Medication Name	Dosage	Date Pres	Times per day	Medication Name	Dosage	Date Pres	Times per day

Signature of Parent/Caregiver (required) _____ **Date** ___/___/___

SECTION 3 FOR ATHLETES WITH DOWN SYNDROME

Persons with Down Syndrome should have a lateral x-ray of the cervical spine in hyperflexion and hyperextension. The interpretation of the radiographs should include measurements of the atlanto-dens interval.

Yes No

Has an x-ray evaluation for atlantoaxial instability been done? If yes, date of x-ray _____

If yes, was it positive for atlantoaxial instability? (positive indicates that the atlanto-dens interval is 5mm or more)

SECTION 4 PHYSICAL EXAMINATION

Blood pressure ___/___ **Weight:** _____ **Height** _____
 Normal/Abnormal Normal/Abnormal Normal/Abnormal
 Vision Cardiovascular system Cranial nerves
 Hearing Respiratory system Coordination
 Oral cavity Gastrointestinal system Reflexes
 Neck Genitourinary system Other _____
 Extremities Skin

Primary MR Etiology/Category: _____

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.

RESTRICTIONS: _____

EXAMINER'S SIGNATURE: _____ DATE: ___/___/___

EXAMINER'S NAME: _____

ADDRESS: _____ PHONE: _____