

CONCUSSION AWARENESS AND SAFETY RECOGNITION POLICY

Objective

It is Special Olympics' intent to take steps to help ensure the health and safety of all Special Olympics participants. All Special Olympics participants should remember that safety comes first and should take reasonable steps to help minimize the risks for concussion or other serious brain injuries.

Defining a Concussion

A concussion is defined by the Centers for Disease Control as a type of traumatic brain injury caused by a bump, blow, or jolt to the head as well as serial, cumulative hits to the head. Concussions can also occur from a blow to the body that causes the head and brain to move quickly back and forth—causing the brain to bounce around or twist within the skull. Although concussions are usually not life-threatening, their effects can be serious and therefore proper attention must be paid to individuals suspected of sustaining a concussion.

Suspected or Confirmed Concussion

Effective January 1, 2015, a participant who is suspected of sustaining a concussion in a practice, game or competition shall be removed from practice, play or competition at that time. If a qualified medical professional is available on-site to render an evaluation, that person shall have final authority as to whether or not a concussion is suspected. If applicable, the participant's parent or guardian should be made aware that the participant is suspected of sustaining a concussion.

Return to Play

A participant who has been removed from practice, play or competition due to a suspected concussion may not participate in Special Olympics sports activities until either of the following occurs (i) at least seven (7) consecutive days have passed since the participant was removed from play and a currently licensed, qualified medical professional provides written clearance for the participant to return to practice, play and competition or (ii) a currently licensed, qualified medical professional determines that the participant did not suffer a concussion and provides written clearance for the participant to return to practice play immediately. Written clearance in either of the scenarios above shall become a permanent record.

The Centers for Disease Control website www.cdc.gov/concussion provides additional resources relative to concussions that may be of interest to participants and their families.

ATHLETE REGISTRATION FORMState Special Olympics Program: South Dakota

Your Delegation: _____

Are you a new athlete to Special Olympics or Re-Registering?

 New Athlete Re-Registering

ATHLETE INFORMATION		
Legal Name First :	Middle Name:	
Legal Name Last:	Preferred Name:	
Date of Birth (mm/dd/yyyy):	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other Gender Identity	
Race/Ethnicity (Optional):		<input type="checkbox"/> Prefer not to answer
<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Asian American	<input type="checkbox"/> More than one race
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	
<input type="checkbox"/> White or Caucasian	<input type="checkbox"/> Hispanic or Latinx	
Language(s) Spoken in Athlete's Home (Optional): Check all that apply		
<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (please List):		
Street Address:		
City:	State:	Zip Code:
Phone:	E-mail:	
Sports/Activities:		
Athlete Employer, if any (Optional):		
Does the athlete have the capacity to consent to medical treatment on his or her own behalf? <input type="checkbox"/> Yes <input type="checkbox"/> No		
PARENT / GUARDIAN INFORMATION (required if minor or otherwise has a legal guardian)		
Name:		
Relationship:		
<input type="checkbox"/> Same Contact Info as Athlete		
Street Address:		
City:	State:	Zip Code:
Phone:	E-mail:	
EMERGENCY CONTACT INFORMATION		
<input type="checkbox"/> Same as Parent/Guardian		
Name:		
Phone:	Relationship:	
PHYSICIAN & INSURANCE INFORMATION		
Physician Name:		
Physician Phone:		
Insurance Company:	Insurance Policy Number:	
Insurance Group Number:		

ATHLETE RELEASE FORM



I agree to the following:

1. **Ability to Participate.** I am physically able to take part in Special Olympics activities.
2. **Likeness Release.** I give permission to Special Olympics, Inc., Special Olympics games organizing committees, and Special Olympics accredited Programs (collectively "Special Olympics") to use my likeness, photo, video, name, voice, and words to promote Special Olympics and raise funds for Special Olympics.
3. **Risk of Concussion and Other Injury.** I know there is a risk of injury. I understand the risk of continuing to play sports with or after a concussion or other injury. I may have to get medical care if I have a suspected concussion or other injury. I also may have to wait 7 days or more and get permission from a doctor before I start playing sports again.
4. **Emergency Care.** If I am unable, or my guardian is unavailable, to consent or make medical decisions in an emergency, I authorize Special Olympics to seek medical care on my behalf, unless I mark one of these boxes:
 - I have a religious or other objection to receiving medical treatment. (Not common.)
 - I do not consent to blood transfusions. (Not common.)
 (If either box is marked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)
5. **Overnight Stay.** For some events, I may stay in a hotel or someone's home. If I have questions, I will ask.
6. **Health Programs.** If I take part in a health program, I consent to health activities, screenings, and treatment. This should not replace regular health care. I can say no to treatment or anything else at any time.
7. **Personal Information.** I understand that Special Olympics will be collecting my personal information as part of my participation, including my name, image, address, telephone number, health information, and other personally identifying and health related information I provide to Special Olympics ("personal information").
 - I agree and consent to Special Olympics:
 - o using my personal information in order to: make sure I am eligible and can participate safely; run trainings and events; share competition results (including on the Web and in news media); provide health treatment if I participate in a health program; analyze data for the purposes of improving programming and identifying and responding to the needs of Special Olympics participants; perform computer operations, quality assurance, testing, and other related activities; and provide event-related services.
 - o using my contact information to communicate with me about Special Olympics.
 - o sharing my personal information with (i) researchers such as universities and public health agencies that are studying intellectual disabilities and the impact of Special Olympics activities, (ii) medical professionals in an emergency, and (iii) government authorities for the purpose of assisting me with any visas required for international travel to Special Olympics events and for any other purpose necessary to protect public safety, respond to government requests, and report information as required by law.
 - I have the right to ask to see my personal information or to be informed about the personal information that is processed about me. I have the right to ask to correct and delete my personal information, and to restrict the processing of my personal information if it is inconsistent with this consent.
 - *Privacy Policy.* Personal Information. Personal information may be shared consistent with this form and as further explained in the Special Olympics privacy policy at www.SpecialOlympics.org/Privacy-Policy
8. **Likeness Release for Sponsors.** Special Olympics relies on sponsors and partners to help support our mission. We often use photos, videos and stories of our athletes to show the impact of support by companies that sponsor Special Olympics. If you wish to allow your likeness to be used in this way, please read and sign below. I agree to the following:
 - I give permission to Special Olympics, Inc., Special Olympics games organizing committees, and Special Olympics accredited Programs (collectively "Special Olympics") and their sponsors and partners to use my likeness, photo, video, name, voice, and words ("my likeness") to acknowledge the sponsors' and partners' support for Special Olympics.
 - Special Olympics and its sponsors and partners will not use my Likeness to endorse commercial products or services.
 - I understand I will not be compensated for the use of my Likeness.

Athlete Name:	E-mail:
ATHLETE SIGNATURE (required for adult athlete with capacity to sign legal documents)	
I have read and understand this form. If I have questions, I will ask. By signing, I agree to this form.	
Athlete Signature:	Date:
PARENT/GUARDIAN SIGNATURE (required for athlete who is a minor or lacks capacity to sign legal documents)	
I am a parent or guardian of the athlete. I have read and understand this form and have explained the contents to the athlete as appropriate. By signing, I agree to this form on my own behalf and on behalf of the athlete.	
Parent/Guardian Signature:	Date:
Printed Name:	Relationship:

Athlete Medical Form

Special Olympics



First name: _____ Last name: _____ Preferred name: _____

Date of birth (mm/dd/yyyy): ____/____/____ Gender: Female Male Other

Email: _____ Phone number: _____ Mobile Landline

Postal address: _____ Country: _____

Emergency Contact -

First name: _____ Last name: _____ Phone number: _____ Mobile Landline

Relationship to athlete: Parent/guardian Caregiver Family member Healthcare provider Coach Other

Qualifying and Associated Conditions - Check all that apply:

Associated Conditions	Autism <input type="checkbox"/>	Cerebral Palsy <input type="checkbox"/>	Down Syndrome <input type="checkbox"/>	Epilepsy <input type="checkbox"/>	Fragile X Syndrome <input type="checkbox"/>
	Fetal Alcohol Syndrome <input type="checkbox"/>	Spina Bifida <input type="checkbox"/>	Marfan Syndrome <input type="checkbox"/>	Other <input type="checkbox"/>	None <input type="checkbox"/>
Please specify other known intellectual disability diagnoses					

Assistive Devices and Accommodations - Do you use any of the following? (Check all that apply):

Mobility	Walker <input type="checkbox"/>	Braces or crutches <input type="checkbox"/>	Wheelchair <input type="checkbox"/>	Prosthetics <input type="checkbox"/>	Removable orthotics <input type="checkbox"/>	None <input type="checkbox"/>
Lifestyle Aids	CPAP <input type="checkbox"/>	Colostomy <input type="checkbox"/>	Dentures <input type="checkbox"/>	Inhaler <input type="checkbox"/>	Glasses, contact lenses, or protective eyewear <input type="checkbox"/>	None <input type="checkbox"/>
Communications	Hearing aid <input type="checkbox"/>	Communication devices <input type="checkbox"/>	Sign language <input type="checkbox"/>	None <input type="checkbox"/>		
Medical Devices	Implantable cardioverter defibrillator (ICD) <input type="checkbox"/>	Implantable device for seizure management <input type="checkbox"/>				
	VP shunt <input type="checkbox"/>	Spinal cord stimulator <input type="checkbox"/>	Pacemaker <input type="checkbox"/>	None <input type="checkbox"/>		

List specific dietary requirements	
Other assistive devices and accommodations	

General Health Questions - Have you ever been diagnosed with or experienced any of the following?

High blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Heat illness	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cardiac condition	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Coeliac disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Enlarged spleen	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Kidney disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hearing impairment	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Bleeding disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Visual impairment	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anemia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Osteoporosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Non-verbal	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you ever had a head injury or concussion?				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Has any family member or relative died of heart problems or of sudden death before age 50?				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you had COVID-19?				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you been immunized for COVID-19?				Yes <input type="checkbox"/>	No <input type="checkbox"/>

Do you have an allergy to any of the following?	Dust <input type="checkbox"/>	Food <input type="checkbox"/>	Insects <input type="checkbox"/>	Animals <input type="checkbox"/>	Plants <input type="checkbox"/>	Grasses <input type="checkbox"/>
	Pollen <input type="checkbox"/>	Drugs or medicine <input type="checkbox"/>	Latex <input type="checkbox"/>	Other <input type="checkbox"/>	None <input type="checkbox"/>	
Please specify allergies						

Have you had any surgeries?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, please list all:
Did you ever have an abnormal Electrocardiogram (EKG) or Echocardiogram (ECHO)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, please specify:
Has a doctor ever limited your participation in sports?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, please specify:
Do you have epilepsy or any type of seizure disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, please specify:
Have you had any broken bones or dislocated joints?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, please specify:
Do you have liver disease?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, please specify:
Do you have lung disease?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, please specify:
Do you have heart disease?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, please specify:
Do you have behavioral, mental health, and/or sensory conditions?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, please specify:

Medication and Treatment - Please list:

Are you taking any prescription or over-the-counter medications or treatments? (Including birth control pills, insulin, multivitamins, allergy shots or pills, asthma inhalers, epilepsy medication, anti-inflammatory medication, supplements of any kind. etc.) Please list:

Medication, Vitamin, or Supplement Name	Dosage	Times per day

Medication, Vitamin, or Supplement Name	Dosage	Times per day

Eligibility to participate

Every person with an intellectual disability who is at least eight years of age is eligible to participate in Special Olympics. A person is considered to have an intellectual disability for purposes of determining his or her eligibility to participate in Special Olympics if that person satisfies any one of the following requirements: (1) The person has been identified by an agency or professional as having an intellectual disability as determined by their localities; or (2) The person has a cognitive delay, as determined by standardized measures such as intelligent quotient or "IQ" testing or other measures which are generally accepted within the professional community in that Accredited Program's nation as being a reliable measurement of the existence of a cognitive delay; or (3) The person has a closely related developmental disability. A "closely related developmental disability" means having functional limitations in both general learning (such as IQ) and in adaptive skills (such as in recreation, work, independent living, self-direction, or self-care). However, persons whose functional limitations are based solely on a physical, behavioral, or emotional disability, or a specific learning or sensory disability, are not eligible to participate as Special Olympics athletes, but may be eligible to volunteer for Special Olympics.

Today's date (mm/dd/yyyy): _____ / _____ / _____

Signature of person completing the form: _____

Is this form being completed by someone other than the athlete? Yes No

If form is being completed by someone other than the athlete, please select the relationship to athlete.

Relationship to athlete: Parent/guardian Caregiver Family member Healthcare provider Coach Other

MEDICAL PHYSICAL INFORMATION (TO BE COMPLETED BY EXAMINER ONLY)

FORM Z

To be completed by a Licensed Medical Professional qualified to conduct physical exams and prescribe medications. If necessary, please use additional pages to list anything else Special Olympics should know about this athlete.

Athlete first and last name: _____ Date of birth (mm/dd/yyyy): ____/____/____

Height (in/cm)	Weight (lb/kg)	Waist circumference (in/cm)	Temperature (°F/°C)	Pulse (bpm)	O2Sat (%)	Blood pressure (mmHG)		Vision (out of 20)	
						systolic	diastolic	os	od

Medical

Eyes, ears, nose, and throat: include pupils, hearing	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Findings:
Heart: include murmurs (auscultation standing, auscultation supine, and ± valsava maneuver)	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Findings:
Lungs	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Findings:
Abdomen	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Findings:
Skin: HSV, MRSA, or tinea corporis	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Findings:
Neurological	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Findings:

Musculoskeletal

Neck	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Findings:
Back	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Findings:
Shoulder and arm	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Findings:
Elbow and forearm	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Findings:
Wrist, hand, and fingers	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Findings:
Hip and thigh	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Findings:
Knee	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Findings:
Lower leg and ankle	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Findings:
Foot and toes	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Findings:

MEDICAL ELIGIBILITY FOR SPORT (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 provide information regarding the licensed healthcare provider below. That provider should complete a referral below and second physician for referral should complete page 4.

- Medically eligible for all sports without restriction
- Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of: _____
- Not medically eligible pending further evaluation of: _____
- Not medically eligible to participate in the following sports: _____
- Not medically eligible for any sports

I have examined the athlete named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date (mm/dd/yyyy): ____/____/____

Address: _____ Phone: _____

Signature of health care professional: _____

NPI or License number: _____ License type (MD, DO, NP, or PA): _____