

ATHLETE REGISTRATION

Dear Special Olympics Athletes, Parents, and Guardians:

Through the power of sports, our athletes find joy, confidence and fulfillment — on the playing field and in life. Whether you are new to Special Olympics or have been involved for years, we are excited you are part of the movement!

To register or re-register as a Special Olympics athlete, please complete the enclosed forms:

- REGISTRATION FORM.** This form asks for contact and other information. (1 Page)
- RELEASE FORM.** This form goes over some important details about Special Olympics participation. (1 Page)
- MEDICAL FORM.** This form is designed to identify health concerns that are more common among people with intellectual disabilities and clear an athlete to participate. Please fill out the Health History section on pages 1 and 2. If you do not understand any parts of the form, you may leave those parts blank to be discussed during the exam. The Physical Exam section on page 3 should be filled out and signed by a licensed medical professional (for example, Physician, Registered Nurse Practitioner, or Physician Assistant).
- CODE OF CONDUCT** Special Olympics is committed to the highest ideals of sport and expects all athletes to honor sport and Special Olympics and are required to abide by the Athlete Code of Conduct. (1 Page)

The Release Form and the Medical Form instruct you to complete other forms in certain uncommon situations. If this applies to you or if you have any other questions, please contact Special Olympics **KERN COUNTY** at 661.383.2906 or kpeterston@sosc.org.

Please submit **ORIGINAL** registration forms by mail or in person (copies, scan or fax cannot be accepted)

Email: kpeterston@sosc.org

Special Olympics – Kern County – 1800 Oak Street, Suite B, Bakersfield, CA 93301

If you have any questions, please do not hesitate to contact our office 661.383.2906

Thank you,

Kellie Peterson | Regional Manager, Sports – Kern County

ATHLETE REGISTRATION FORM

Special Olympics



State Special Olympics Program: Kern County -

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

ATHLETE INFORMATION		
First Name:		Middle Name:
Last Name:		Preferred Name:
Date of Birth (mm/dd/yyyy):		<input type="checkbox"/> Female <input type="checkbox"/> Male
Race/Ethnicity (Optional):		
<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Two or More Races
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	
<input type="checkbox"/> White	<input type="checkbox"/> Hispanic or Latino (specific origin group: _____)	
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:	Postal 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:	Postal 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 Medical Form – HEALTH HISTORY

(To be completed by the athlete or parent/guardian/caregiver and brought to Exam)



Athlete's First and Last Name: _____

HAS THE ATHLETE EVER BEEN DIAGNOSED WITH OR EXPERIENCED ANY OF THE FOLLOWING CONDITIONS

Loss of Consciousness	<input type="checkbox"/> No <input type="checkbox"/> Yes	High Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	Stroke/TIA	<input type="checkbox"/> No <input type="checkbox"/> Yes
Dizziness during or after exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes	High Cholesterol	<input type="checkbox"/> No <input type="checkbox"/> Yes	Concussions	<input type="checkbox"/> No <input type="checkbox"/> Yes
Headache during or after exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes	Vision Impairment	<input type="checkbox"/> No <input type="checkbox"/> Yes	Asthma	<input type="checkbox"/> No <input type="checkbox"/> Yes
Chest pain during or after exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hearing Impairment	<input type="checkbox"/> No <input type="checkbox"/> Yes	Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Shortness of breath during or after exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes	Enlarged Spleen	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hepatitis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Irregular, racing or skipped heart beats	<input type="checkbox"/> No <input type="checkbox"/> Yes	Single Kidney	<input type="checkbox"/> No <input type="checkbox"/> Yes	Urinary Discomfort	<input type="checkbox"/> No <input type="checkbox"/> Yes
Congenital Heart Defect	<input type="checkbox"/> No <input type="checkbox"/> Yes	Osteoporosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Spina Bifida	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Attack	<input type="checkbox"/> No <input type="checkbox"/> Yes	Osteopenia	<input type="checkbox"/> No <input type="checkbox"/> Yes	Arthritis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Cardiomyopathy	<input type="checkbox"/> No <input type="checkbox"/> Yes	Sickle Cell Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Heat Illness	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Valve Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Sickle Cell Trait	<input type="checkbox"/> No <input type="checkbox"/> Yes	Broken Bones	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Murmur	<input type="checkbox"/> No <input type="checkbox"/> Yes	Easy Bleeding	<input type="checkbox"/> No <input type="checkbox"/> Yes	Dislocated Joints	<input type="checkbox"/> No <input type="checkbox"/> Yes
Endocarditis	<input type="checkbox"/> No <input type="checkbox"/> Yes	If female athlete, list date of last menstrual period: _____			

Describe any past broken bones or dislocated joints

(if yes is checked for either of those fields above):

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List any other ongoing or past medical conditions:

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Neurological Symptoms for Spinal Cord Compression and Atlanto-axial Instability

Difficulty controlling bowels or bladder	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Numbness or tingling in legs, arms, hands or feet	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Weakness in legs, arms, hands or feet	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Head Tilt	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Spasticity	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Paralysis	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes

PLEASE LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW

(includes inhalers, birth control or hormone therapy)

Medication, Vitamin or Supplement Name	Dosage	Times per Day	Medication, Vitamin or Supplement Name	Dosage	Times per Day	Medication, Vitamin or Supplement Name	Dosage	Times per Day

Is the athlete able to administer his or her own medications? No Yes

Name of Person Completing this Form Relationship to Athlete Phone Email

Athlete Medical Form – **MEDICAL REFERRAL FORM**

(To be completed by a Licensed Medical Professional only if referral is needed)



Athlete's First and Last Name: _____

This page only needs to be completed and signed if the physician on page three does not clear the athlete and indicates further evaluation is required.

Athlete should bring the previously completed pages to the appointment with the specialist.

Examiner's Name: _____

Specialty: _____

I have been asked to perform an additional athlete exam for the following medical concern(s) - *Please describe:*

- Concerning Cardiac Exam Acute Infection O₂ Saturation Less than 90% on Room Air
 Concerning Neurological Exam Stage II Hypertension or Greater Hepatomegaly or Splenomegaly
 Other, please describe:

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

- Yes** **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



EMERGENCY MEDICAL CARE REFUSAL FORM – PARENT OR GUARDIAN COMPLETION

(To be completed by parent or guardian of athlete who is a minor or lacks capacity to sign legal documents)

Instructions: Only complete this form if you do not consent to emergency medical care on religious or other grounds and have marked a box under the Emergency Care provision on the Athlete Release Form.

I am the parent/guardian of the athlete named below and agree to the following:

1. **No Consent to Emergency Medical Care.** I understand that Special Olympics' standard registration form requires athletes or their parents or guardians to consent to emergency medical care for the athlete if needed in an emergency. Based on religious beliefs or other reasons I am not consenting to emergency medical care as follows.

YOU MUST MARK THE BOX AND WRITE YOUR INITIALS NEXT TO ONE STATEMENT TO CONFIRM YOUR INTENT:

- I DO NOT CONSENT TO ANY KIND OF MEDICAL TREATMENT, EVEN IN A LIFE-THREATENING EMERGENCY. INITIALS: _____**
- I DO NOT CONSENT TO BLOOD TRANSFUSIONS, EVEN IN A LIFE-THREATENING EMERGENCY. I CONSENT TO ALL OTHER KINDS OF EMERGENCY MEDICAL CARE. INITIALS: _____**

2. **Accompaniment of Athlete.** I understand that I must be present in order to take personal responsibility for the athlete if any medical treatment is to be refused on the athlete's behalf in a medical emergency arises. This includes during meal times, in overnight accommodations, at training sessions and competitions, and during travel to and from Special Olympics activities.
3. **Emergency Medical Care If Athlete Is Not Accompanied.** I understand that, if I am not present and actively taking personal responsibility for the athlete during a medical emergency, Special Olympics may seek emergency medical care for the athlete as recommended by medical professionals responding to the emergency.
4. **Liability Release.** On behalf of myself and the athlete, I release Special Olympics, its employees, and its volunteers from all claims that may arise out of taking or failing to take measures to provide the athlete with emergency medical care. I am agreeing to this release because I have refused, knowingly and voluntarily, to give Special Olympics permission to take emergency measures, and I am expressly withholding consent to emergency medical care on religious or other grounds. For this form, "Special Olympics" means all Special Olympics organizations.

Athlete Name:	E-mail:
PARENT/GUARDIAN SIGNATURE	
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. This release shall be binding upon me, the athlete and our respective heirs and legal representatives.	
Parent/Guardian Signature:	Date:
Printed Name:	Relationship:



ATLANTO-AXIAL INSTABILITY (AAI) SPECIAL RELEASE FORM

(SPECIAL RELEASE CONCERNING SPINAL CORD COMPRESSION AND ATLANTO-AXIAL INSTABILITY)

Instructions: Only complete this form if symptoms of spinal cord compression or Atlanto-axial instability were found in a pre-participation examination and a doctor then provided clearance for participation following a neurological evaluation.

I agree to the following:

1. **Spinal Cord Compression Symptoms.** In a pre-participation examination, a licensed medical professional found symptoms that might be the result of spinal cord compression or Atlanto-axial instability.
2. **Neurological Evaluation.** After a neurological evaluation, a qualified doctor concluded that:
 - The cause of the symptoms will not result in additional risk of neurological injury due to participation in sports, and
 - Participation in Special Olympics activities is safe without restrictions or with restrictions that will be shared with Special Olympics and followed.
3. **Liability Release.** I acknowledge that I have been informed of the findings and determinations of the physician. I release and hold harmless Special Olympics from all claims in connection with possible spinal cord compression or Atlanto-axial instability. For this form, "Special Olympics" means all Special Olympics organizations.

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. This release shall be binding upon me, the athlete and our respective heirs and legal representatives.	
Parent/Guardian Signature:	Date:
Printed Name:	Relationship:



CODE OF CONDUCT ATHLETE

Special Olympics is committed to the highest ideals of sport and expects all athletes to honor sport and Special Olympics and are required to abide by the following Code of Conduct:

Respect for Others

- I will practice good sportsmanship.
- I will act in ways that bring respect to me, my coaches, my team and Special Olympics.
- I will be safe and courteous to others.

Positive Training and Competition Behaviors

- I will regularly attend training for my sport.
- I will be on time for any training or competition.
- I will learn and follow the rules of my sport.
- I will listen and follow the instructions of my coaches and the officials and ask questions when I do not understand.
- I will always try my best during training and at competitions.
- I will not "hold back" in preliminary competition just to get into an easier final competition division.
- I will fully participate as a member of my Team including traveling and staying with overnight with my Team.

Taking Responsibility For My Actions

- I will obey all laws and Special Olympics rules
- I will only smoke in designated areas and not while participating in a Special Olympics training or competition.
- I will not drink alcohol or use illegal drugs at Special Olympics events.
- I will not use bad language or insult other athletes, coaches, volunteers or staff.
- I will not fight with other athletes, coaches, volunteers or staff.
- I will not make inappropriate or unwanted sexual advances to others.
- I will follow the Special Olympics policy that says athletes cannot date volunteers.

I understand that if I do not obey this Code of Conduct, I will be subject to a range of consequences by Special Olympics up to and including not being allowed to participate.

Print Name of Athlete or Parent/Guardian Date

Signature of Athlete or Parent/Guardian Date

PARTNERSHIP

Special Olympics
Southern California
Kern & Inyo County



Dear New Athlete,

Society for Disabled Children and Special Olympics Kern County Region are excited to offer you an opportunity to participate and compete as a Special Olympics Athlete.

You will train during program hours and have the opportunity to compete against local programs at championships.

Enclosed you will find our Application for Participation, an Overview of Special Olympics, and a Down Syndrome Form (**if applicable**). The Application for Participation is ten (10) pages. Please return your **original** completed application **with blue sections completed by a licensed medical examiner** to Shelley Goodell or Beth Carstens.

If you have additional questions, please contact:

Partnership Director(s) – Shelley Goodell or Beth Carstens – 661.322.5595

Special Olympics Regional Manager, Sports & Programs – Kellie Peterson 661-383-2906

kpeterson@sosc.org

Special Olympics Kern County provides year-round sports training and competition in a variety of Olympic-type sports for children and adults with intellectual disabilities. Special Olympics gives these individuals continuing opportunities to develop physical fitness, demonstrate courage, experience joy, and participate in a sharing of gifts, skills, and friendship with their community. – Mission Statement

•“Let me win, but if I can not win, let me be brave in the attempt” – Athlete Oath

Athlete Oath:

“Let me win, but if I cannot win,
let me be brave in the attempt”

Special Olympics Southern California - Kern County Region

1800 Oak St. Ste. B, Bakersfield CA 93301 Tel: 661-383-2909 Fax: 661-383-2908

Email: kpeterson@sosc.org

Website: www.sosc.org/kerncounty

Created by the Joseph P. Kennedy Jr. Foundation for the benefit of persons with intellectual disabilities