Application for participation in Special Olympics Missouri

Physical examination required every 3 years

Please Print

Agency Name: ______________________ Agency Number: ______________ New Athlete Renewal

First ______________________ MI ______________ Last ______________________

Gender: Male Female Athlete SSN ______________ Date of Birth ______________

Athlete's Email address ______________________ Athlete Employer ______________

Athlete's Address (Complete) ______________________ City ______________

Zip ________ Phone ______________________ Cell Phone ______________

Parent/Guardian Name ______________________

Parent/Guardian Email address ______________________ Guardian Employer ______________

Parent/Guardian Address (Complete) ______________________ City ______________

Zip ________ Phone ______________________ Cell Phone ______________

Emergency Contact Person ______________________ Phone ______________

Health Insurance Company ______________________ Medicaid ______________

Health History

		Circle One				Circle One	
1.	Heart Disease/heart defect/high blood pressure	Yes	No	12.	Bone or joint problems	Yes	No
2	Chest pain	Yes	No	13.	Special Diet	Yes	No
3.	Seizures/epilepsy/fainting spells	Yes	No	14.	Asthma	Yes	No
4.	Diabetes	Yes	No	15.	Tobacco Use	Yes	No
5.	Concussion or serious head injury	Yes	No	16.	Easy Bleeding	Yes	No
6.	Major surgery or serious illness	Yes	No	17.	Emotional/psychiatric/behavioral	Yes	No
7.	Heat stroke/exhaustion	Yes	No	18.	Sickle cell trait or disease	Yes	No
8.	Visual impairment/contact lenses/glasses	Yes	No	19.	Immunizations up to date	Yes	No
9.	Blind	Yes	No	20.	Down Syndrome**	Yes	No
10	Hearing Impaired	Yes	No	21.	Autism	Yes	No
11	Deaf/Complete hearing loss	Yes	No	22.	Intellectual Disability	Yes	No

***athletes with Down Syndrome must complete the Atlanto-Axial Instability Assessment found on the Release form.*

Allergies ______________________

Please print medication name, amount, date prescribed and number of times per day medication is given. Attach extra sheet of paper if needed. ______________________

I acknowledge that Special Olympics Missouri has an Athlete Housing Policy relative to housing arrangements and the policy is available on the SOMO website at www.somo.org.

Signature of parent/caregiver/adult athlete

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To be completed by a health care professional:

Physical Examination

Blood Pressure _______/________ Weight ______________ Height ______________

				Normal (N)	*Abnormal (A)*			
Vision	N	A	Cardiovascular System	N	A	Cranial Nerves	N	A
Hearing	N	A	Respiratory System	N	A	Coordination	N	A
Oral Cavity	N	A	Gastrointestinal System	N	A	Reflexes	N	A
Neck	N	A	Genitourinary System	N	A	Skin	N	A
Extremities	N	A						

Other: ______________________

Primary MR Etiology/Category ______________________

Restrictions: ______________________

Examiner's Name: ______________________ Address: ______________________

City: ______________ Zip code ______________ Phone ______________

Examiner's Signature ______________________ **Date** ______________

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 Missouri.

Updated 4.23.14