

Instructions for Completing the Application for Participation

The Application for Participation (App) must be filled in completely. Apps with blank sections or attachments (exception: letter from State Office of Guardianship, 2a below) will not be accepted.

This App is valid for 2 years from the date of the examination date, regardless of the parent/guardian/Entrant signature date.

Parent/guardian and doctor signatures must be original and both original signatures must be on the same App form. Faxed signatures, phone consents or verbal consents will not be accepted.

If Entrant was listed on the Sex Offender Public Registry or the Child Murder and Violent Offender Against Youth Registry but has since been removed, contact the Special Olympics Illinois office for instructions before submitting this application.

ATHLETE INFORMATION AND HEALTH INSURANCE & EMERGENCY INFORMATION

1. The first two sections must be filled in completely. The ethnicity information is requested to assist in the organizational outreach efforts.

PARENT AND/OR GUARDIAN AUTHORIZATION AND MEDIA RELEASE

2. The Parent or Legal Guardian must read, sign and date the Parent/Guardian Authorization and Media Release.

a. The section must be signed and dated as printed. Deletions or alterations to the section will result in an invalid App. (Exception: Deletion of the last paragraph regarding medical treatment and attachment of a letter of explanation and 24-hour emergency telephone numbers from the State Office of Guardianship. **As of January 1, 1987, the letter of explanation must be attached.**)

b. Only one of the two signature blocks must be completed. Special Olympics Illinois works under the understanding that this section may be signed by either:

- ♦The (biological or adoptive) parent unless the athlete has been designated a ward of the state;

OR

- ♦The legal guardian; this person must be legally assigned for the individual;

OR

♦The athlete if he/she is over the age of 18 and has not been designated as needing and having been assigned a legal guardian. A witness signature is necessary if the athlete's signature is unrecognizable (for example, if the athlete's signature is an "X.")

MEDICAL CLEARANCE

3. The Medical Clearance section must be completed, signed and dated by a medical practitioner licensed to administer physical examinations by the state in which he/she practices. **As of September 1, 1990, the Special Olympics Illinois Application for Participation is the only Medical Clearance form which will be accepted as valid by Special Olympics Illinois.**

This person, by signing the Medical Clearance, is stating that the athlete is in good health and can safely participate in Special Olympics sports training and competition. It is strongly suggested that the person administering the physical examination possess the following:

- ♦Background and preparation in giving sports physical examinations.
- ♦Qualifications to administer examinations that would not compromise his/her area of specialty.

AFTER COMPLETING THE APPLICATION ...

4. Send the original copy of the Application for Participation to the Area Director who will send the App to the Special Olympics Illinois Chapter office. The Chapter office will validate the Application for Participation and send a copy of the App with an approved stamp back to the SOAD (Special Olympics Athletic Director). An Application for Participation will not be validated until all information is correct and completed on the approved form.

5. Special Olympics Illinois requires that all Applications for Participation be presented prior to and no later than the established Medical App deadline of a Chapter championship level event (Winter Games, State Basketball Tournament, Summer Games, Outdoor Sports Festival, Fall Games, Floor Hockey or State Bowling Tournament). All Apps for the event in question must be valid throughout the completion of that Chapter competition.

Applications for Participation for athletes participating in District Tournaments and Sectional Tournaments must be received before the entry deadline or with registration materials.

Applications not on file or in receipt by the specified deadline will not be accepted.



Special Olympics
Illinois



APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS ILLINOIS

Valid Application for Participation is mandatory for all competitors
605 E. Willow St. • Normal, IL 61761-2682 • 309-888-2551

SO ILL Rev. 8-1-10

ATHLETE INFORMATION

Athlete Name (last name, space, first name) _____ Birthdate

M	M	D	D	Y	Y
---	---	---	---	---	---

Agency Name _____ Sex (M or F)

--	--	--	--	--	--

Athlete's Mailing Address _____ Parents/Guardian's (Please Circle One) Home Address _____

Athlete's City _____ Parents/Guardian's City _____

State _____ State _____ Zip Code _____ Zip Code _____

Ethnicity White Black/African American Asian
 Hispanic/Latino Other _____ Parents/Guardian's Home Telephone _____

HEALTH INSURANCE & EMERGENCY INFORMATION (Required for Processing)

Person to be contacted in case of emergency _____ Emergency Contact Phone (_____) _____

Medical Insurance Company _____ Policy Number _____

PARENT AND/OR GUARDIAN AUTHORIZATION AND MEDIA RELEASE

I, on my own behalf or as the undersigned parent and/or legal guardian of the above named applicant (hereafter referred to as the "Entrant"), hereby request permission for the Entrant to participate in Special Olympics programs. I acknowledge that Special Olympics will screen all entrants using the Sex Offender Public Registry and the Child Murder and Violent Offender Against Youth Registry and understand that entrants listed on either Registry will be denied participation. I affirm that this Entrant has never been on said Registries or, if Entrant was listed on either Registry but has since been removed, I will contact Special Olympics Illinois for instructions before submitting this application. I represent and warrant to you that the Entrant is physically and mentally able to participate in Special Olympics, and I submit herewith a subscribed medical certificate. I understand that if the athlete has Down Syndrome, he/she cannot participate in sports or events which, by their nature result in hyper-extension, radical flexion or direct pressure on the neck or upper spine unless a full radiological examination establishes the absence of Atlantaoaxial instability. I am aware that the sports and events for which this radiological examination is required are equestrian sports, artistic gymnastics, diving, pentathlon, high jump, alpine skiing, soccer, soccer skills, powerlifting squat and butterfly stroke and diving starts in swimming. On behalf of the Entrant and myself, I acknowledge that the Entrant will be using facilities at his/her own risk and I, on my own behalf, herby release, discharge and indemnify Special Olympics from all liability for injury to person or damage to property of myself and Entrant.

In permitting the Entrant to participate, I am specifically granting permission to Special Olympics Illinois to use the likeness, voice and words of the Entrant in television, radio, films, newspapers, magazines and other media, and in any form not heretofore described, for the purpose of advertising or communicating the purposes and activities of Special Olympics and in appealing for funds to support such activities. I understand that by signing below I consent for the Entrant to participate in the Special Olympics Healthy Athletes Program that provides individual screening assessments of health status and health care needs. The Entrant has no obligation to participate and I understand the Entrant should seek his/her own medical advice and assistance and Special Olympics is not responsible for the Entrant's health.

If I am not personally present at Special Olympics activities in which the Entrant is to compete, so as to be consulted in case of necessity, you are authorized on my behalf and at my account to take such measures and arrange for such medical and hospital treatment as you may deem advisable for the health and well-being of the Entrant.

I, THE UNDERSIGNED ADULT ENTRANT, have read and fully understand the provisions of the above release and/or have had them explained. I hereby agree that I will be bound thereby and I shall defend Special Olympics Illinois and hold it harmless from disaffirmation thereof.

Entrant _____ Signature of Parent
Witness _____ and/or Legal Guardian
(Check appropriate box) _____
Date _____ Print Name _____

Athlete's Email Address _____ Parent's Email Address _____

Original parent/guardian and doctor signatures are required by the office of Special Olympics Illinois. Faxed signatures will not be accepted.

MEDICAL CLEARANCE

PLEASE CHECK MEDICAL INFORMATION

Does athlete have Down Syndrome? Yes No
If yes, have x-rays of the C1-C2 vertebrae been taken and examined? Yes No

Date of x-ray _____ Is the athlete clear of Atlantaoaxial instability? Yes No

Does the athlete have or is the athlete:
Heart Problems Yes No
Diabetic Yes No
Epileptic/Seizures Yes No
Blind Yes No
Deaf Yes No
Hepatitis Yes No
Other _____

Current Medication _____ Dosage _____

Allergies to medication, if any: _____
Date of last Tetanus shot: _____

I have examined the above-named Entrant and, in my opinion, there is no mental or physical reason why he or she should not participate in the Special Olympics sports training and competition program. Further information will be forwarded if required. Current medication, if any, is specified with dosage on this application.

Examination Date _____
Doctor's Signature _____
Print Name _____
Address _____
City _____ State _____ Zip _____
Phone (_____) _____

SRSNLC Annual Information Form

2012

Lindenhurst
 Round Lake
 Waukegan
 Zion

This information will be used for all programs during 2012.
 Please contact your local office if any information changes throughout the year.

Name: _____		Age: _____	Birth Date: _____
Address: _____		City: _____	State _____ Zip: _____
Parent/Guardian Name: _____		E-mail: _____	
Home Phone: (____) _____		Cell Phone: (____) _____	
Mother's Work Phone: (____) _____		Father's Work Phone: (____) _____	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	T-Shirt Size _____		
School/Workshop: _____	Teacher/Supervisor: _____	Phone: (____) _____	
Physician's Name: _____		Physician's Phone: (____) _____	
Address: _____		City: _____	State _____ Zip: _____

EMERGENCY CONTACT (Within 20 mile radius) Other than parent/guardian

Name: _____	Relationship: _____
Address: _____	Home Phone: (____) _____
City: _____ State: _____ Zip: _____	Work/Cell Phone: (____) _____

PARTICIPANT DISABILITY (Please check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Attention Deficit Disorder: (ADD)
<input type="checkbox"/> Autism (A)
<input type="checkbox"/> Behavior Disorder (BD)
<input type="checkbox"/> BiPolar (BP)
<input type="checkbox"/> Brain Injury (BI)
<input type="checkbox"/> Deaf/Hard of Hearing (D/HH)
<input type="checkbox"/> Developmental Disability (DD)
<input type="checkbox"/> Down Syndrome (DS)
<input type="checkbox"/> Early Childhood (EC)
<input type="checkbox"/> Educable Mental Handicap (EMH) | <input type="checkbox"/> Emotionally Distressed (ED)
<input type="checkbox"/> Learning Disorder (LD)
<input type="checkbox"/> Multiply Challenged (MC)
<input type="checkbox"/> Physically Challenged (PC)
Yes / No • are orthopedic devices worn? _____
Yes / No • can transfer into van seat or stadium seat.....
<input type="checkbox"/> Severe Mental Handicap (SMH)
<input type="checkbox"/> Trainable Mental Handicap (TMH)
<input type="checkbox"/> Visually Impaired (VI) |
|--|---|

If Down Syndrome, has participant been tested for atlanto axial instability? Yes / No
 Does your participant have atlanto axial instability? Yes / No

PHOTO/VIDEO AUTHORIZATION AND CONSENT:

I hereby authorize and give my consent to SRSNLC to photograph/video my child (or me), and without limitation, to use such photographs/video in connection with promoting/advertising the services, programs, and facilities of SRSNLC, including, but not limited to its website, Facebook page, promotional materials, brochures, fliers and other publications without consideration of any kind. **I have read and fully understand the above photo/video authorization and consent.**

Signature of Parent/Guardian _____ Date _____

EMERGENCY TREATMENT PERMISSION:

I acknowledge that SRSNLC does not carry medical insurance. My family's own health insurance must assume responsibility in the event of injury. I understand that every precaution is taken to protect the safety of every participant. I agree to emergency treatment by a physician or hospital in the event that I cannot be reached. I hereby acknowledge that the above information is accurate and I understand that it is my responsibility to inform the SRSNLC staff of any changes in the above information.

Medical Insurance Company _____ Date _____

Policy Number _____ Signature of Parent/Guardian _____

MEDICATION

Does the participant receive any medication? Yes No

Medication

Dosage

Purpose

Side Effects

<u>Medication</u>	<u>Dosage</u>	<u>Purpose</u>	<u>Side Effects</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HEALTH ISSUES

Does the participant seizure? Yes No Comments: _____

Does the participant have asthma? Yes No _____

Does the participant have allergies? Yes No _____

DIETARY ISSUES

Does participant require assistance eating or drinking? Yes No Comments: _____

• have any food restrictions? Yes No Comments: _____

• have any food dislikes? Yes No Comments: _____

• have any specific food likes? Yes No Comments: _____

• is participant Diabetic? Yes No Comments: _____

BEHAVIOR ISSUES

Does participant display unusual fears? Yes No Comments: _____

• comply with verbal requests? Yes No Comments: _____

• respond to specific directions? Yes No Comments: _____

• have any known situations that cause behaviors? Yes No Comments: _____

What actions are to be taken if a particular behavior is presented? _____

• respond to any reinforcement devices? Yes No Comments: _____

• respond to any behavior improvement techniques? Yes No Comments: _____

SAFETY ISSUES

Does participant need assistance orientating to:
people _____ place _____ time _____

Does participant need assistance protecting:
self _____ anticipating safety needs _____

Does participant need assistance toileting:
independent _____ monitor _____
diapering _____ other: _____

GENERAL ISSUES

Does participant use:
wheelchair _____ stroller _____ walker _____
cane _____ canadian crutches _____

If participant is non-verbal do they use: sign language _____
communication board/book _____

Does participant swim/enjoy water? Yes No