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:

☐ **ATHLETE RELEASE FORM AND ATHLETE LIKENESS RELEASE FOR SPONSORS.** Please read the forms, print the participant’s name, sign, and date. The Athlete Likeness Release for Sponsors form is optional.

☐ **ATHLETE REGISTRATION AND MEDICAL FORM.** The registration form asks for contact and other information. The medical 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).

All forms must be correctly completed and postmarked or emailed by 11:59pm by the appropriate deadline date.

- Basketball & Gymnastics: February 1
- Athletics (Track & Field), Powerlifting, Soccer & Swimming: April 1
- Softball, Tee Ball, Tennis, Golf & Bocce: June 1
- Flag Football: September 15
- Bowling & Volleyball: October 1
- Skiing, Snowboarding, Snowshoeing & Unified 3v3 Basketball: December 1

The Athlete Release Form and Athlete Medical Form instruct you to complete additional forms in certain situations. If this applies to you or if you have any other questions, please contact the Athlete Records Manager for Special Olympics Wisconsin, Inc., at (608) 442-5677 or by email at ssotelo@specialolympicswisconsin.org

Please submit the forms to medicals@specialolympicswisconsin.org or the address below:

Special Olympics Wisconsin
2310 Crossroads Dr., Ste. 1000
Madison, WI 53718
ATHLETE REGISTRATION FORM

Local Special Olympics Program: ____________________________________________

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

<table>
<thead>
<tr>
<th>ATHLETE INFORMATION</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name:</td>
<td>Middle Name:</td>
</tr>
<tr>
<td>Last Name:</td>
<td>Preferred Name:</td>
</tr>
<tr>
<td>Date of Birth (mm/dd/yyyy):</td>
<td>☐ Female ☐ Male</td>
</tr>
<tr>
<td>Race/Ethnicity (Optional):</td>
<td></td>
</tr>
<tr>
<td>☐ American Indian/Alaskan Native</td>
<td>☐ Asian</td>
</tr>
<tr>
<td>☐ Black or African American</td>
<td>☐ Native Hawaiian or Other Pacific Islander</td>
</tr>
<tr>
<td>☐ White</td>
<td>☐ Hispanic or Latino (specific origin group:________________________)</td>
</tr>
<tr>
<td>Language(s) Spoken in Athlete’s Home (Optional): Check all that apply</td>
<td></td>
</tr>
<tr>
<td>☐ English</td>
<td>☐ Spanish</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Street Address:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>City:</td>
<td>State:</td>
</tr>
<tr>
<td>Phone:</td>
<td>E-mail:</td>
</tr>
</tbody>
</table>

Sports/Activities:

Athlete Employer, if any (Optional):

Does the athlete have the capacity to consent to medical treatment on his or her own behalf? □ Yes □ No

PARENT / GUARDIAN INFORMATION (required if minor or otherwise has a legal guardian)

<table>
<thead>
<tr>
<th>Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Relation:</td>
<td></td>
</tr>
<tr>
<td>☐ Same Contact Info as Athlete</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Street Address:</th>
<th></th>
</tr>
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<td>City:</td>
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<tr>
<td>Phone:</td>
<td>E-mail:</td>
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</tbody>
</table>

EMERGENCY CONTACT INFORMATION

<table>
<thead>
<tr>
<th>Name:</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Phone:</td>
<td>Relationship:</td>
</tr>
<tr>
<td>☐ Same as Parent/Guardian</td>
<td></td>
</tr>
</tbody>
</table>

PHYSICIAN & INSURANCE INFORMATION

<table>
<thead>
<tr>
<th>Physician Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Phone:</td>
<td></td>
</tr>
<tr>
<td>Insurance Company:</td>
<td>Insurance Policy Number:</td>
</tr>
<tr>
<td>Insurance Group Number:</td>
<td></td>
</tr>
</tbody>
</table>
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, words, and biographical information 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, dormitory 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:
     - 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.
     - using my contact information for communicating with me about Special Olympics.
     - sharing my personal information confidentially 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 may be used and shared consistent with this form and as further explained in the Special Olympics privacy policy at [www.SpecialOlympics.org/Privacy-Policy](http://www.SpecialOlympics.org/Privacy-Policy).

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<table>
<thead>
<tr>
<th><strong>Athlete Name:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ATHLETE SIGNATURE</strong> (required for adult athlete with capacity to sign legal documents)</td>
</tr>
<tr>
<td>I have read and understand this form. If I have questions, I will ask. By signing, I agree to this form.</td>
</tr>
<tr>
<td>Athlete Signature:</td>
</tr>
</tbody>
</table>

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</thead>
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<tr>
<td>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.</td>
</tr>
<tr>
<td>Parent/Guardian Signature:</td>
</tr>
<tr>
<td>Printed Name:</td>
</tr>
</tbody>
</table>
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, words, and biographical information (“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.

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</table>

| Printed Name: | Relationship: |
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

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 the removal or return to play of the participant. 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 (1) 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 (2) 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 Medical Form – HEALTH HISTORY**

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

**Athlete First & Last Name:** ___________________________          **Preferred Name:** ___________________________

**Athlete Date of Birth (mm/dd/yyyy):** ___________________________          **Female**  **Male**

**STATE PROGRAM:** ___________________________          **E-mail:** ___________________________

### ASSOCIATED CONDITIONS - Does the athlete have (check any that apply):

- [ ] Autism  
- [ ] Down Syndrome  
- [ ] Fragile X Syndrome  
- [ ] Cerebral Palsy  
- [ ] Fetal Alcohol Syndrome  
- [ ] Other Syndrome, please specify: ___________________________

### ALLERGIES & DIETARY RESTRICTIONS

- [ ] No Known Allergies  
- [ ] Latex  
- [ ] Medications: ________________________________________________  
- [ ] Insect Bites or Stings: _________________________________________  
- [ ] Food: ________________________________________________________

List any special dietary needs:

### ASSISTIVE DEVICES - Does the athlete use (check any that apply):

- [ ] Brace  
- [ ] Colostomy  
- [ ] Communication Device  
- [ ] C-PAP Machine  
- [ ] Crutches or Walker  
- [ ] Dentures  
- [ ] Glasses or Contacts  
- [ ] G-Tube or J-Tube  
- [ ] Hearing Aid  
- [ ] Implanted Device  
- [ ] Inhaler  
- [ ] Pacemaker  
- [ ] Removable Prosthetics  
- [ ] Splint  
- [ ] Wheel Chair

### SPORTS PARTICIPATION

List all Special Olympics sports the athlete wishes to play:

**Has a doctor ever limited the athlete’s participation in sports?**

- [ ] No  
- [ ] Yes

If yes, please describe:

### SURGERIES, INFECTIONS, VACCINES

List all past surgeries:

**Does the athlete currently have any chronic or acute infection?**

- [ ] No  
- [ ] Yes

If yes, please describe:

**Has the athlete ever had an abnormal Electrocardiogram (EKG) or Echocardiogram (Echo)?**

- [ ] Yes, had abnormal EKG  
- [ ] Yes, had abnormal Echo

**Has the athlete had a Tetanus vaccine in the past 7 years?**

- [ ] No  
- [ ] Yes

### EPILEPSY AND/OR SEIZURE HISTORY

**Epilepsy or any type of seizure disorder**

- [ ] No  
- [ ] Yes

If yes, list seizure type: ________________________________________________

**If yes, had seizure during the past year?**

- [ ] No  
- [ ] Yes

### MENTAL HEALTH

**Self-injurious behavior during the past year**

- [ ] No  
- [ ] Yes

**Depression (diagnosed)**

- [ ] No  
- [ ] Yes

**Aggressive behavior during the past year**

- [ ] No  
- [ ] Yes

**Anxiety (diagnosed)**

- [ ] No  
- [ ] Yes

Describe any additional mental health concerns:

### FAMILY HISTORY

**Has any relative died of a heart problem before age 50?**

- [ ] No  
- [ ] Yes

**Has any family member or relative died while exercising?**

- [ ] No  
- [ ] Yes

List all medical conditions that run in the athlete’s family:
Athlete’s First and Last Name: ________________________________

<table>
<thead>
<tr>
<th>HAS THE ATHLETE EVER BEEN DIAGNOSED WITH OR EXPERIENCED ANY OF THE FOLLOWING CONDITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of Consciousness</td>
</tr>
<tr>
<td>Dizziness during or after exercise</td>
</tr>
<tr>
<td>Headache during or after exercise</td>
</tr>
<tr>
<td>Chest pain during or after exercise</td>
</tr>
<tr>
<td>Shortness of breath during or after exercise</td>
</tr>
<tr>
<td>Irregular, racing or skipped heart beats</td>
</tr>
<tr>
<td>Congenital Heart Defect</td>
</tr>
<tr>
<td>Heart Attack</td>
</tr>
<tr>
<td>Cardiomyopathy</td>
</tr>
<tr>
<td>Heart Valve Disease</td>
</tr>
<tr>
<td>Heart Murmur</td>
</tr>
<tr>
<td>Endocarditis</td>
</tr>
</tbody>
</table>

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):

List any other ongoing or past medical conditions:

<table>
<thead>
<tr>
<th>Neurological Symptoms for Spinal Cord Compression and Atlanto-axial Instability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty controlling bowels or bladder</td>
</tr>
<tr>
<td>Numbness or tingling in legs, arms, hands or feet</td>
</tr>
<tr>
<td>Weakness in legs, arms, hands or feet</td>
</tr>
<tr>
<td>Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet</td>
</tr>
<tr>
<td>Head Tilt</td>
</tr>
<tr>
<td>Spasticity</td>
</tr>
<tr>
<td>Paralysis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PLEASE LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW (includes inhalers, birth control or hormone therapy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication, Vitamin or Supplement Name</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

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

Name of Person Completing this Form | Relationship to Athlete | Phone | Email |
|------------------------------------|------------------------|-------|-------|

Medical Form for US Programs – updated July 2017
Athlete Medical Form – PHYSICAL EXAM
(To be completed by a Licensed Medical Professional qualified to conduct physical exams and prescribe medications)

Athlete’s First and Last Name:

MEDICAL PHYSICAL INFORMATION
(To be completed by a Licensed Medical Professional qualified to conduct physical exams and prescribe medications)

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>BMI (optional)</th>
<th>Temperature</th>
<th>Pulse</th>
<th>O₂Sat</th>
<th>Blood Pressure (in mmHg)</th>
<th>Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>cm</td>
<td>kg</td>
<td></td>
<td>C</td>
<td></td>
<td></td>
<td>BP Right:</td>
<td></td>
</tr>
<tr>
<td>in</td>
<td>lbs</td>
<td>Body Fat %</td>
<td>F</td>
<td></td>
<td></td>
<td>BP Left:</td>
<td></td>
</tr>
</tbody>
</table>

- Right Hearing (Finger Rub): ☐ Responds ☐ No Response ☐ Can’t Evaluate
- Left Hearing (Finger Rub): ☐ Responds ☐ No Response ☐ Can’t Evaluate
- Right Ear Canal: ☐ Clear ☐ Cerumen ☐ Foreign Body
- Left Ear Canal: ☐ Clear ☐ Cerumen ☐ Foreign Body
- Right Tympanic Membrane: ☐ Clear ☐ Perforation ☐ Infection ☐ NA
- Left Tympanic Membrane: ☐ Clear ☐ Perforation ☐ Infection ☐ NA
- Oral Hygiene: ☐ Good ☐ Fair ☐ Poor
- Thyroid Enlargement: ☐ No ☐ Yes
- Lymph Node Enlargement: ☐ No ☐ Yes
- Heart Murmur (supine): ☐ No ☐ 1/6 or 2/6 ☐ 3/6 or greater
- Heart Murmur (upright): ☐ No ☐ 1/6 or 2/6 ☐ 3/6 or greater
- Heart Rhythm: ☐ Regular ☐ Irregular
- Lungs: ☐ Clear ☐ Not clear
- Right Leg Edema: ☐ No ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+
- Left Leg Edema: ☐ No ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+
- Radial Pulse Symmetry: ☐ Yes ☐ R>L ☐ L>R
- Cyanosis: ☐ No ☐ Yes, describe
- Clubbing: ☐ No ☐ Yes, describe
- Bowel Sounds: ☐ Yes ☐ No
- Hepatomegaly: ☐ No ☐ Yes
- Splenomegaly: ☐ No ☐ Yes
- Abdominal Tenderness: ☐ No ☐ RUQ ☐ RLQ ☐ LUQ ☐ LLQ
- Kidney Tenderness: ☐ No ☐ Right ☐ Left
- Right upper extremity reflex: ☐ Normal ☐ Diminished ☐ Hyperreflexia
- Left upper extremity reflex: ☐ Normal ☐ Diminished ☐ Hyperreflexia
- Right lower extremity reflex: ☐ Normal ☐ Diminished ☐ Hyperreflexia
- Left lower extremity reflex: ☐ Normal ☐ Diminished ☐ Hyperreflexia
- Spasticity: ☐ No ☐ Yes, describe below
- Tremor: ☐ No ☐ Yes, describe below
- Abnormal Gait: ☐ No ☐ Yes, describe below
- Neck & Back Mobility: ☐ Full ☐ Not full, describe below
- Upper Extremity Mobility: ☐ Full ☐ Not full, describe below
- Lower Extremity Mobility: ☐ Full ☐ Not full, describe below
- Upper Extremity Strength: ☐ Full ☐ Not full, describe below
- Lower Extremity Strength: ☐ Full ☐ Not full, describe below
- Loss of Sensitivity: ☐ No ☐ Yes, describe below
- Hyperreflexia: ☐ Normal ☐ Diminished ☐ Hyperreflexia

SPINAL CORD COMPRESSION & ATLANTO-AXIAL INSTABILITY (AAI) (Select one)
- ☐ Athlete shows NO EVIDENCE of neurological symptoms or physical findings associated with spinal cord compression or atlanto-axial instability.
- ☐ Athlete has neurological symptoms or physical findings that could be associated with spinal cord compression or atlanto-axial instability and must receive an additional neurological evaluation to rule out additional risk of spinal cord injury prior to clearance for sports participation.

ATHLETE CLEARANCE TO PARTICIPATE (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 make a referral below and second physician for referral should complete page 4.

☐ This athlete is ABLE to participate in Special Olympics sports without restrictions.
☐ This athlete is ABLE to participate in Special Olympics sports WITH restrictions. Describe ➔
☐ This athlete MAY NOT participate in Special Olympics sports at this time & MUST be further evaluated by a physician for the following concerns:
- ☐ 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:

Additional Licensed Examiner’s Notes and Recommended (but not required) Follow-up:
- ☐ Follow up with a cardiologist
- ☐ Follow up with a vision specialist
- ☐ Follow up with a podiatrist
- ☐ Follow up with a neurologist
- ☐ Follow up with a hearing specialist
- ☐ Follow up with a physical therapist
- ☐ Follow up with a primary care physician
- ☐ Follow up with a dentist or dental hygienist
- ☐ Follow up with a nutritionist

Other/Exam Notes:

Name:
E-mail:
License #:

Signature of Licensed Medical Examiner
Exam Date
Phone:

Medical Form for US Programs – updated July 2017
Special Olympics Medical Form | 3 of 4
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