



Be a fan.

Welcome to Special Olympics Maryland – Montgomery!

- Enclosed you will find our required 2-sided Special Olympics athlete participation form.
- Before participating in any sport, **athletes** must have this **APPLICATION FOR PARTICIPATION** (medical) and official Special Olympics **RELEASE FORM** on file with the county office (SOMO) and with the state office (SOMD)
- This 2-sided form must be returned to **Carol Halderman**, our medical director, and a copy taken to the coach at your first (or next) practice.
- **Your physician must complete and must SIGN – not stamp side 2 of the medical form, and it must be dated. When filling out this form, please PRINT CLEARLY, and complete all of the information. THIS IS VITAL INFORMATION AND MUST BE CLEARLY UNDERSTOOD TO PROTECT OUR ATHLETES AND TO PROVIDE IMPORTANT DETAILS IN CASE OF AN EMERGENCY.**
- You may attach any additional information pertinent to the athlete's participation in our sports programs (IE: itemized list of prescription medications, explanation of any yes" answers, health and/or behavioral concerns). **NOTE:** For athletes living in a group home, please be sure that COUNSELOR contact information is clearly indicated in employer/counselor box. Please check that the form is completely filled out as incomplete forms cannot be accepted and will delay the start of your training and could interfere with participation in competition.
 - **Please return the completed form to: Carol Halderman - 9327 Grazing Terrace - Gaithersburg - MD – 20886**
- If you have any questions, please call the voice hotline (888) 924-6965 and follow the prompts to leave a message for the medical director. Completed forms will be forwarded to the state office for processing. An athlete is **NOT ELIGIBLE TO TRAIN OR COMPETE UNTIL THIS PROCESS IS COMPLETED.**
- Several weeks prior to the start of each sport season (early August for Fall, early November for Winter, and early March for Spring) athletes should go online at www.somdmontgomery.org and sign up for the sport/sports they choose to train in. They may also mail in their sport sign- up form that they receive in the newsletter. Many of our sports training programs have limited roster space and athletes interested in those sports should respond as soon as notice of the training season in the newsletter has been made. The names of all of the athletes who have signed up to train in a sport will be collected and passed on to the coach. Training dates, times and locations will be in the newsletter and you should show up for the first practice on time and ready to play!

Please see details regarding eligibility to participate in Special Olympics on reverse side.

- **Welcome to our Montgomery County Special Olympics Family!**

Carol Halderman

Medical Director, S.O.MO. Management Team

S.O.MO. – PO Box 1809 Rockville, MD 20849 – (888) 924-6965 Voicemail / Hotline
Pamela D. Yerg , Area Director - jeyclan@verizon.net - www.somdmontgomery.org
Area Director mailing address: 10204 Colebrook Ave. Potomac MD 20854



Be a fan.

Please share this information with your physician.

**Eligibility to Participate in Special Olympics
(Condensed from Article 6.01 of the General Rules)**

Special Olympics training and competition is open to every person who

- 1 Has been identified by an agency or professional as having intellectual disability (mental retardation or closely related developmental disability), or
- 2 Has a cognitive delay, as determined by standardized measures, or
- 3 Has a closely related developmental disability which means having functional limitations in both general learning and in adaptive skills (such as in recreational, work, independent living, self-direction, or self-care).

To simplify, for children of school- age (6-21) if they receive an IEP (Individual Education Plan) this makes them eligible for participation as an athlete in Special Olympics.

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 as partners in Unified Sports.

Participation in Special Olympics training and competition is open to every person with intellectual disability regardless of how mild or severe the person's disability, and whether or not that person also has other mental or physical disabilities. There is not maximum age limitation for participation in Special Olympics. The minimum age requirement for participation in Special Olympics competition is eight year of age. Children 6-7 years of age may participate in age-appropriate Special Olympics training programs but may not participate in Special Olympics competition or be awarded medals or ribbons associated with competition. Children 3-6 years may participate in YAP-Young Athletes Program. All persons who are eligible to participate in Special Olympics training and/or competition programs must register to participate with their local accredited program.

Special Olympics State office:
Special Olympics Maryland
513 Progress Drive Suite P
Linthicum MD 21090
(410)-789-6677 / 800-541-7544
www.somd.org

Special Olympics MD- Montgomery County office:
Pamela D. Yerg, Area Director
PO Box 1809 Rockville MD 20849
jevclan@verizon.net / www.somdmontgomery.org

APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS MARYLAND (valid for 3 years)

COUNTY _____ SOC. SEC # _____ DOB ____/____/____

FEMALE or MALE ATHLETE or UNIFIED PARTNER NEW ATHLETE or CURRENT

ATHLETE INFORMATION

NAME _____
 ADDRESS _____
 CITY/STATE/ZIP _____
 HOME PHONE (____) _____ FAX (____) _____
 CELL PHONE (____) _____
 E-MAIL _____
 HEALTH/ACCIDENT INSURANCE CO _____
 POLICY # _____

ETHNICITY (OPTIONAL) CHECK ALL THAT APPLY CAUCASIAN ASIAN
 AMERICAN AFRICAN AMERICAN MEXICAN CARIBBEAN
 HISPANIC OTHER

SCHOOL / AGENCY / EMPLOYER

NAME _____
 ADDRESS _____
 CITY/STATE/ZIP _____
 PHONE (____) _____ FAX (____) _____

PARENT / GUARDIAN INFORMATION

NAME _____
 ADDRESS _____
 CITY/STATE/ZIP _____
 HOME PHONE (____) _____ FAX (____) _____
 CELL PHONE (____) _____
 E-MAIL _____

EMPLOYER

NAME _____
 ADDRESS _____
 CITY/STATE/ZIP _____
 PHONE (____) _____ FAX (____) _____

EMERGENCY CONTACT (IF OTHER THAN PARENT)

NAME _____
 PHONE (____) _____
 CELL PHONE (____) _____

PARENT / GUARDIAN INFORMATION

YES	NO		YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	*HEART DISEASE / HEART DEFECT / HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	*CHEST PAIN	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	*SEIZURES / EPILEPSY / FAINTING SPELLS	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	*DIABETES	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	*CONCUSSION OR SERIOUS HEAD INJURY	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	*MAJOR SURGERY OR SERIOUS ILLNESS	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	*BLINDNESS / SEVERE VISUAL PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	*ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	SICKLE CELL TRAIT OR DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	BONE OR JOINT PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	MISSING ONE KIDNEY	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	EMOTIONAL / PSYCHIATRIC / BEHAVIORAL PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>

(*) REQUIRES PHYSICAL EXAM IF NEW PROBLEM

<input type="checkbox"/>	HEAT STROKE / EXHAUSTION
<input type="checkbox"/>	FALSE TEETH / DENTURES
<input type="checkbox"/>	TOBACCO USE
<input type="checkbox"/>	EASY BLEEDING
<input type="checkbox"/>	HEARING LOSS / SEVERE HEARING PROBLEM / HEARING AID
<input type="checkbox"/>	CONTACT LENSES / GLASSES
<input type="checkbox"/>	OTHER HEALTH ISSUES
<input type="checkbox"/>	SPECIAL DIET (specify)
<input type="checkbox"/>	ALLERGY TO MEDICINES (specify)
<input type="checkbox"/>	ALLERGY TO FOOD (specify)
<input type="checkbox"/>	ALLERGY TO INSECT STING / BITE (specify)
<input type="checkbox"/>	DATE OF LAST TETANUS SHOT
<input type="checkbox"/>	IMMUNIZATIONS UP TO DATE

HAS ATHLETE EVER BEEN CHARGED / CONVICTED OF A CRIMINAL OFFENSE? YES NO

HAS ATHLETE EVER BEEN CHARGED WITH ABUSE OF ASSAULT? YES NO

DOES ATHLETE HAVE ANY PENDING CRIMINAL CASES? YES NO

IS ATHLETE NOW ON PROBATION FOR ANY CRIMINAL OR TRAFFIC VIOLATION? YES NO

HAS ATHLETE EVER BEEN FOUND "NOT CRIMINALLY RESPONSIBLE" FOR ANY CRIMINAL OR TRAFFIC OFFENSE? YES NO

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE EXPLAIN THE DATES AND DETAILS OF EACH CASE ON A SEPARATE SHEET OF PAPER

MEDICATIONS

NAME OF MEDICATION	DOSAGE (MM)	TIMES PER DAY	DATE OF PRESCRIPTION

SIGNATURE – PLEASE SIGN BELOW TO INDICATE THAT ALL OF THE ABOVE INFORMATION IS CORRECT, ACCURATE AND UP-TO-DATE

SIGNATURE OF PARENT/GUARDIAN/ADULT ATHLETE _____ DATE ____/____/____

PLEASE COMPLETE SIDE 2 OF THIS APPLICATION

SIGN

APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS MARYLAND / SIDE TWO

PHYSICAL EXAMINATION

ATHLETE NAME _____

BLOOD PRESSURE _____ HEIGHT _____ ft _____ inches WEIGHT _____ lbs

PREIMARY MR ETIOLOGY/CATEGORY _____ IF PREGNANT, DUE DATE ____/____/____

	NORMAL	ABNORMAL		NORMAL	ABNORMAL		NORMAL	ABNORMAL			
<input type="checkbox"/>	<input type="checkbox"/>	VISION	<input type="checkbox"/>	<input type="checkbox"/>	GARDIOVASCULAR SYSTEM	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY SYSTEM	<input type="checkbox"/>	<input type="checkbox"/>	NECK
<input type="checkbox"/>	<input type="checkbox"/>	HEARING	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY SYSTEM	<input type="checkbox"/>	<input type="checkbox"/>	CRANIAL NERVES	<input type="checkbox"/>	<input type="checkbox"/>	SKIN
<input type="checkbox"/>	<input type="checkbox"/>	ORAL CAVITY	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTNAL SYSTEM	<input type="checkbox"/>	<input type="checkbox"/>	COORDINATION	<input type="checkbox"/>	<input type="checkbox"/>	REFLEXES
<input type="checkbox"/>	<input type="checkbox"/>	EXTREMITIES									

COMMENTS _____

RESTRICTIONS

I AM A LICENSED MEDICAL PROFESSIONAL. I HAVE REVIEWED THE ACCOMPANYING HEALTH INFORMATION AND HAVE PERFORMED THE ABOVE EXAMINATION ON THIS ATHLETE WITHIN THE LAST 6 MONTHS AND CERTIFY THAT THE ATHLETE CAN PARTICIPATE IN SPECIAL OLYMPICS.

EXAMINER'S NAME _____ PHONE (____) _____

ADDRESS _____

CITY/STATE/ZIP _____

EXAMINER'S SIGNATURE _____ DATE ____/____/____

FOR ATHLETES WITH DOWN SYNDROME

PERSONS WITH DOWN SYNDROME MUST HAVE A LATERAL X-RAY OF THE CERVICAL SPINE IN PYPERFLEXSION AND HYPEREXTENSION. THE INTERPRETATION OF THE RADIOGRAPHYS MUST INCLUDE MEASUREMENTS OF THE ATLANTO-DENS INTERVAL.

YES	NO	YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HAS AN X-RAY EVALUATION FOR ATLANTOAXIAL INSTABILITY BEEN DONE?		IF YES, WAS THE ANTLANTO-DENS INTERVALA 5MM OR MORE?	

OFFICIAL SPECIAL OLYMPICS RELEASE FORM

I, _____, am at least 18 years old and have submitted this application for participation in Special Olympics.

I represent and warrant that, to the best of my knowledge and belief, I am physically and mentally able to participate in Special Olympics activities. I also represent that a licensed physician has reviewed the health information contained in my application and has certified based on an independent medical examination, that there is no medical evidence which would preclude me from participating in Special Olympics. I understand that if I have Down syndrome, I cannot participate in sports or events which by their nature result in hyper-extension, radical flexion or direct pressure to my neck or upper spine unless I have a full radiological examination which established the absence of Atlanto-axial instability. I am aware that I must have this radiological examination before I can participate in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing and soccer.

Special Olympics has my permission, (both during and anytime after) to use my likeness, name, voice, or words in either television, radio, film, newspapers, magazines and other media, and in any form, for the purpose of advertising or communicating the purposes and activities of Special Olympics and/or applying for funds to support those purposes and activities.

If, during my participation in Special Olympics activities, I should need emergency medical treatment, and I am not able to give my consent or make my own arrangements for treatment, because of my injuries, I authorize Special Olympics to take whatever measures are necessary to protect my health and well-being, including, if necessary, hospitalization.

I, the athlete named above, have read this paper and fully understand the provisions of the release that I am signing. I understand that by signing this paper that I agree to the provisions of this release.

Signature of adult athlete _____ Date ____/____/____

I herby certify that I have reviewed this release with the athlete whose signature appears above. I am satisfied based on that review that the athlete understands this release and has agreed to the provisions of this release.

Name (print) _____ Relationship to athlete _____

I am the parent/guardian of _____, the minor athlete, on whose behalf I have submitted this application for participation in Special Olympics. I hereby represent that the athlete has my permission to participate in Special Olympics activities.

I further represent and warrant that, to the best of my knowledge and belief, the athlete is physically and mentally able to participate in Special Olympics. With my approval, a licensed physician has reviewed the health information set forth in the athlete's application and has certified based on an independent medical examination, that there is no medical evidence which would preclude the athlete's participation. 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 to the neck or upper spine unless the athlete has a full radiological examination which establishes the absence of Atlanto-axial instability. I am aware that the sports events for which this radiological examination is required are equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing and soccer.

In permitting the athlete to participate, I am specifically granting my permission, (both during and anytime after) to special Olympics to use the athlete's likeness, name, voice, or words in either television, radio, film, newspapers, magazines and other media, and in any form, for the purpose of advertising or communicating the purposes and activities of Special Olympics and/or applying for funds to support those purposes and activities.

If a medical emergency should arise during the athlete's participation in any Special Olympics activities, at a time when I am not personally present so as to be consulted regarding the athlete's care, I hereby authorize Special Olympics to take whatever measures are necessary to ensure that the athlete is provided with any emergency medical treatment, including hospitalization, which Special Olympics deems advisable in order to protect the athlete's health and well-being.

I am the parent/guardian of the athlete named in this application. I have read and fully understand the provisions of the above release, and have explained these provisions to the athlete. Through my signature on this release form, I am agreeing to the above provisions on my own behalf and on the behalf of the athlete named herein.

I hereby give my permission for the athlete named above to participate in Special Olympics Games, recreation programs and physical activity programs.

Signature of Parent/Guardian _____ Date ____/____/____

Name (print) _____