

ATHLETE REGISTRATION PACKET

Special Olympics
Maine



Dear Special Olympics Athletes, Parents, and Guardians:

Through the power of sports, people with intellectual disabilities discover new strengths and abilities, skills and success. Our athletes find joy, confidence and fulfillment — on the playing field and in life. They also inspire people in their communities and elsewhere to open their hearts to a wider world of human talents and potential.

To register to become a Special Olympics athlete, please complete the enclosed forms:

☐ **ATHLETE REGISTRATION FORM.** This form is required for all athletes and asks for contact information and health history. The second part of this form includes the waivers, releases and policies form. This section includes is the registration form and goes over risks, use of likenesses, emergency medical care, consent for health program participation, personal information, and other important details about Special Olympics participation. Waivers, releases, and policies help create a safe and supportive environment, ensuring everyone's health, safety, and dignity are respected.

☐ **ADHERE TO ATHLETE CODE OF CONDUCT.** Review Athlete Code of Conduct at www.somaine.org/wp-content/uploads/2015/02/Athletes-Code-of-Conduct.pdf

Yearly registration renewal form:

☐ **ATHLETE REGISTRATION RENEWAL FORM.** Please complete this form every year following your initial registration. The purpose of a yearly Athlete Registration Renewal Form is to update and capture any changes in an athlete's health or medication. This ensures that the most current information is on file, helping coaches and medical personnel provide appropriate care and support, and ensuring the safety and well-being of the athlete during participation.

☐ **ATHLETE SUPPLEMENTAL FORMS-** <https://www.somaine.org/resources/athlete-resources/athlete-registration-forms/>

- Athlete Medical Form - Special Olympics Maine encourages all participants to get a yearly physical examination.
- Atlanto-Axial Instability (AAI) Special Release Form
- Emergency Medical Care Refusal Form

Please submit completed Athlete Registration forms (original) to:

- BY EMAIL: SarahP@somaine.org
- FX: 1-888-490-0672

Recommendation: Make 2 copies of the completed original Athlete Registration forms:

1. Originals – send to SOMaine State office (see above)
2. Copy 1 – send to Head Coach of Athlete's Delegation
3. Copy 2 – Safekeeping. Keep an extra copy somewhere safe in case original is misplaced.

Thank you. We are excited you are part of the Special Olympics Maine Movement!

Athlete Registration Form

Required for all athletes participating in Special Olympics.

Special Olympics
Maine



Local Special Olympics Program: _____

Athlete Information - To be completed by the athlete or parent/guardian/caregiver.

First name: _____ Last name: _____ Middle name: _____

Date of birth (mm/dd/yyyy): ____/____/____ Gender: Female Male Other

Email: _____ Phone number: _____ Mobile Landline

Home address: _____

Optional – Check all that apply:

Race / Ethnicity	American Indian / Alaskan Native Black / African American Middle Eastern / North African White / Caucasian Other: _____	Asian American Hispanic / Latino Native Hawaiian / Other Pacific Islander Unknown Prefer not to answer
Language(s) Spoken by Athlete	English French Spanish Other (please list): _____	American Sign Language (ASL)

Parent/Guardian Information - Required if minor or otherwise has a legal guardian.

First Name: _____ Last Name: _____ Relationship to athlete: _____

Email: _____ Phone number: _____ Mobile Landline

Home address: _____

Emergency Contact

Same as Parent/Guardian

First name: _____ Last name: _____ Phone number: _____ Mobile Landline

Relationship to athlete: Parent/guardian Caregiver Family member Healthcare provider Coach Other

Associated Conditions - Mandatory

Associated Conditions	Autism Marfan Syndrome Other	Cerebral Palsy Spina Bifida Unknown	Down Syndrome Epilepsy	Fetal Alcohol Syndrome Fragile X Syndrome
Check all that apply:				
Please specify other known intellectual disability diagnoses:				

Assistive Devices and Accommodations - Do you use any of the following? Check all that apply:

Mobility	Walker Prosthetics	Braces or crutches None	Wheelchair	Removable orthotics
Lifestyle Aids	CPAP None	Dentures	Glasses, contact lenses, or protective eyewear	
Communications	Hearing Aid	Communication devices	Sign Language	None
Medical Devices	Implantable cardioverter defibrillator (ICD) VP Shunt	Pacemaker	Implantable device for seizure management None	

Do you have a specific dietary requirement?	Yes	No	If yes, please specify:
Do you use other assistive devices?	Yes	No	If yes, please specify:

General Health Questions

Do you have a heart condition?	Yes	No
Do you have asthma?	Yes	No
Do you have diabetes that requires you to take insulin?	Yes	No
Do you have a vision impairment?	Yes	No
Do you have a hearing impairment?	Yes	No
Do you have a bleeding disorder?	Yes	No
Has a doctor ever limited your participation in sports?	Yes	No
Do you have epilepsy or any type of seizure disorder?	Yes	No
Do you have sickle cell disease?	Yes	No

Have you ever had a concussion?	Yes	No	If yes, please specify how many in your lifetime: _____ Date of last one (mm/yyyy): _____
Do you have behavioral, mental health, and/or sensory conditions?	Yes	No	If yes, please specify:
Do you have severe allergies that requires the use of an EpiPen?	Yes	No	If yes, please specify if it is to any of the following: Insect stings Medication/drugs Food Latex Other (please specify): _____

Medication and Treatment - Please list:

Are you taking any prescription or over-the-counter medications or treatments? (Including birth control pills, insulin, multivitamins allergy shots or pills, EpiPen, asthma inhalers, epilepsy medication, anti-inflammatory medication, supplements of any kind. etc.)

Yes No

If yes, please list:

Medication, Vitamin, or Supplement Name	Dosage	Times per day

Medication, Vitamin, or Supplement Name	Dosage	Times per day

Name of person completing the form: _____

Today's date (mm/dd/yyyy): ____/____/____

Is this form being completed by someone other than the athlete? Yes No

If yes, please select the relationship to athlete:

Relationship to athlete: Parent/guardian Caregiver Family member Healthcare provider Coach Other

Special Olympics encourages all participants to get a yearly physical examination.

WAIVERS, RELEASES, AND POLICIES

Please read the following information and check boxes fully before signing.

I agree to the following:

1. **Ability to Participate.** I am physically able to take part in Special Olympics activities, and will abide by all applicable rules, requirements and codes of conduct.
2. **Likeness Release.** I give permission to Special Olympics, Inc., Special Olympics games organizing committees, Special Olympics accredited Programs (collectively "Special Olympics"), as well as official Special Olympics supporters and partners that have authorization from Special Olympics, to use my likeness, photo, video, name, voice, words, biographical information and similar or related material (my "likeness") to promote Special Olympics and raise funds for Special Olympics. I understand that my likeness may be used in all forms of media in local or global campaigns – including those by supporters and partners of Special Olympics – but understand that my likeness will not be used to endorse commercial products or services. I understand that I will not be compensated for the use of my likeness.
3. **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.
 - ☐ I do not consent to blood transfusions.(If either box is marked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)
4. **Overnight Stay.** For some events, overnight accommodations may be required. If I have questions, I will contact my Special Olympics Program.
5. **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 have the right to decline Health programming treatment (which is different from sideline or emergency medical care) at any time."
6. **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.

SYMPTOMS FOR SPINAL CORD COMPRESSION and ATLANTOAXIAL INSTABILITY (For athlete with Down syndrome only)

If I (or the athlete) have been diagnosed with or experienced any of the following symptoms that have increased in severity over the past three years – difficulty controlling bowels or bladder; numbness or tingling in legs, arms, hands, or feet; weakness in arms, legs, hands or feet; burner/stinger/pinches nerve, pain in neck, back shoulders, arms, hands, buttocks, legs or feet; spasticity or paralysis – I must obtain a review and permission from a licensed medical practitioner to train and/or participate in Special Olympics activities.

WAIVER AND RELEASE OF LIABILITY / ASSUMPTION OF RISK / INDEMNIFICATION

In consideration of being allowed to participate in any way in Special Olympics activities, the undersigned acknowledges, appreciates, and agrees that:

1. While particular rules and personal discipline may reduce this risk, the risk of illness (including communicable diseases), injury (including concussion), disability, and death does exist;
2. If I observe any unusual or significant hazard during my presence or participation, I will remove myself from participation and bring such to the attention of the nearest Special Olympics representative immediately; and,
3. **I understand the risks involved with participation in Special Olympics activities. I fully accept and assume all risks and all responsibility for losses, costs, and damages I may incur as a result of my participation. To the fullest extent of the law, I release and agree not to sue any Special Olympics organization, its directors, agents, volunteers, and employees, other participants, sponsoring agencies, sponsors, advertisers, and, if applicable owners and lessors of premises on which any Special Olympics activity is occurring ("Releasees") related to any liabilities, claims, or losses on my account caused or alleged to be caused in whole or in part by the Releasees even if arising from the negligence of the Releasees. I have read this release of liability and assumption of risk provision, fully understand its terms, acknowledge that I have given up substantial rights by signing it, and sign it freely and voluntarily without any inducement. I further agree that if, despite this release, I, or anyone on my behalf, makes a claim against any of the Releasees, I will indemnify and hold harmless each of the Releasees from any such liabilities, claims, or losses as the result of such claim. I agree that if any part of this form is held to be invalid, the other parts shall continue in full force and effect.**

Athlete Name: _____

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 (mm/dd/yyyy): ____/____/____

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.

Parent/Guardian Signature: _____

Date (mm/dd/yyyy): ____/____/____

Printed Name: _____

Relationship: _____

EVALUATION AND RESEARCH (Optional)

Special Olympics wants to help our athletes and their families stay healthy and happy. We may take part in research studies and would share information for your potential participation. All studies will be checked by the Special Olympics Chief Health Officer.

Would you or your family be interested in learning about research studies?

Yes

No