

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

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

FEMALE or MALE ATHLETE or PARTNER NEW ATHLETE or CURRENT ATHLETE

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 (____) _____

HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER:

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	*HEART DISEASE / HEART DEFECT / HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	HEAT STROKE / EXHAUSTION
<input type="checkbox"/>	<input type="checkbox"/>	*CHEST PAIN	<input type="checkbox"/>	<input type="checkbox"/>	FALSE TEETH / DENTURES
<input type="checkbox"/>	<input type="checkbox"/>	*SEIZURES / EPILEPSY / FAINTING SPELLS	<input type="checkbox"/>	<input type="checkbox"/>	TOBACCO USE
<input type="checkbox"/>	<input type="checkbox"/>	*DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	EASY BLEEDING
<input type="checkbox"/>	<input type="checkbox"/>	*CONCUSSION OR SERIOUS HEAD INJURY	<input type="checkbox"/>	<input type="checkbox"/>	HEARING LOSS / SEVERE HEARING PROBLEM / HEARING AID
<input type="checkbox"/>	<input type="checkbox"/>	*MAJOR SURGERY OR SERIOUS ILLNESS	<input type="checkbox"/>	<input type="checkbox"/>	CONTACT LENSES / GLASSES
<input type="checkbox"/>	<input type="checkbox"/>	*BLINDNESS / SEVERE VISUAL PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>	OTHER HEALTH ISSUES
<input type="checkbox"/>	<input type="checkbox"/>	*ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	SPECIAL DIET (specify)
<input type="checkbox"/>	<input type="checkbox"/>	SICKLE CELL TRAIT OR DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGY TO MEDICINES (specify)
<input type="checkbox"/>	<input type="checkbox"/>	BONE OR JOINT PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGY TO FOOD (specify)
<input type="checkbox"/>	<input type="checkbox"/>	MISSING ONE KIDNEY	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGY TO INSECT STING / BITE (specify)
<input type="checkbox"/>	<input type="checkbox"/>	EMOTIONAL / PSYCHIATRIC / BEHAVIORAL PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>	DATE OF LAST TETANUS SHOT
<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS	<input type="checkbox"/>	<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

Physician