Permission Slip for Lexington MedFest

October 24, 2019

Southland Christian Church – Richmond Road Location - Lexington, KY

September 2019

Dear Adult Athlete, Parent or Legal Guardian,

Special Olympics Kentucky is organizing a *MedFest*, a one-day event to provide free sports physicals as well as vision, hearing and dental screenings for adult independent Special Olympics Athletes. You will be notified of any screening results that may need further attention and receive a signed copy of the Medical Form. We are excited about this opportunity for our athletes!

I give permission for my athlete, (**First Name**)_____(**Last Name**)_____ to attend MedFest on Thursday, October 24, 2019 at Southland Christian Church located off Richmond Road for *MedFest* by signing below. My signature indicates my permission for me or my athlete to receive a free sport physical and vision, hearing and dental screenings. My signature also gives Special Olympics Kentucky my permission to release all forms completed at *MedFest* to any necessary medical professionals.

If Adult athlete (over the age of 18 and are your own legal guardian)

_____	_____	_____
Print Athletes Name	**Athlete's Signature**	**Date**

If you are not your own legal guardian (under the age of 18)

_____	_____	_____
Print Parent's Name	**Parent's Signature**	**Date**

Emergency Contact Name _____ Cell Phone or day phone #: _____

Please list any dietary restrictions *MedFest* staff should be aware of?

_____

_____

_____

As a souvenir for attending this event, all participants will receive a t-shirt, please circle your son/daughter's size:

Youth Sizes: **Small** **Medium** **Large**

Adult Sizes: **Small** **Medium** **Large** **X-Large** **2XL** **3XL**

Time available to attend MedFest is:

☐ **8:30 am**

Return this permission slip along with the athlete registration/medical form (all 4 pages) completely filled out and signed in the highlighted areas to:

Special Olympics Kentucky
Attn: Lexington MedFest Registration
105 Lakeview Court
Frankfort, KY 40601

Registration deadline is Monday, September 30, 2019

You will receive a confirmation and further instructions regarding Lexington MedFest 2 weeks prior to the event.

ATHLETE REGISTRATION FORM

Special Olympics

Special Olympics State Program: Kentucky - 2019 Lexington Medfest

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

ATHLETE INFORMATION		
First Name:	**Middle Name:**	
Last Name:	**Preferred Name:**	
Date Birth (mm/dd/yyyy):	☐ Female ☐ Male	
Race/Ethnicity (Optional): ☐ American Indian/Alaskan Native ☐ Asian ☐ Two or More Races ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Hispanic or Latino (specific origin group:_____)		
Language(s) Spoken in Athlete's Home (Optional): Check all that apply ☐ English ☐ Spanish ☐ Other (please list):		
Street Address:		
City:	**State:**	**Postal Code:**
Phone:	**E-mail:**	
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)		
Name:		
Relationship:		
☐ **Same Contact Info as Athlete**		
Street Address:		
City:	**State:**	**Postal Code:**
Phone:	**E-mail:**	
EMERGENCY CONTACT INFORMATION		
☐ **Same as Parent/Guardian**		
Name:		
Phone:	**Relationship:**	
PHYSICIAN / INSURANCE INFORMATION		
Physician Name:		
Physician Phone:		
Insurance Company:	**Insurance Policy Number:**	
Insurance Group Number:		

ATHLETE RELEASE FORM

Special Olympics

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 to use my photo, video, name, voice, and words to promote Special Olympics and raise funds for Special Olympics. For this form, "Special Olympics" means all Special Olympics organizations.
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 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.
   - ☐ I do not consent to blood transfusions.

   (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 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 is collecting my personal information.
   - I 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 operations and activities; and provide event-related services.
   - I consent to Special Olympics using my email address and creating a profile of me for communications and marketing purposes.
   - I understand that Special Olympics may disclose my personal information to medical professionals in the event of an emergency and to third party researchers to analyze data for the purposes of improving Special Olympics programming and identifying and responding to the needs of Special Olympics participants.
   - I understand that Special Olympics may disclose my personal information to 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 understand Special Olympics is a global organization with headquarters in the United States of America. I consent to Special Olympics storing and processing my personal information in countries, including the United States of America, that have laws requiring a different level of privacy and data protection.
   - 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 make changes to or delete my information.

ATHLETE NAME: _____ Email: _____

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: _____

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: _____

Printed Name: _____ Relationship: _____

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:_____

ASSISTED 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

List any special dietary needs:

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)? *If yes, describe date and results*
☐ 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
Aggressive behavior during the past year ☐ No ☐ Yes
Depression *(diagnosed)* ☐ 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 Medical Form – **HEALTH HISTORY**

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

Athlete's First and Last Name:_____

HAS THE ATHLETE EVER BEEN DIAGNOSED WITH OR EXPERIENCED ANY OF THE FOLLOWING CONDITIONS

Loss of Consciousness	☐ No ☐ Yes	High Blood Pressure	☐ No ☐ Yes	Stroke/TIA	☐ No ☐ Yes
Dizziness during or after exercise	☐ No ☐ Yes	High Cholesterol	☐ No ☐ Yes	Concussions	☐ No ☐ Yes
Headache during or after exercise	☐ No ☐ Yes	Vision Impairment	☐ No ☐ Yes	Asthma	☐ No ☐ Yes
Chest pain during or after exercise	☐ No ☐ Yes	Hearing Impairment	☐ No ☐ Yes	Diabetes	☐ No ☐ Yes
Shortness of breath during or after exercise	☐ No ☐ Yes	Enlarged Spleen	☐ No ☐ Yes	Hepatitis	☐ No ☐ Yes
Irregular, racing or skipped heart beats	☐ No ☐ Yes	Single Kidney	☐ No ☐ Yes	Urinary Discomfort	☐ No ☐ Yes
Congenital Heart Defect	☐ No ☐ Yes	Osteoporosis	☐ No ☐ Yes	Spina Bifida	☐ No ☐ Yes
Heart Attack	☐ No ☐ Yes	Osteopenia	☐ No ☐ Yes	Arthritis	☐ No ☐ Yes
Cardiomyopathy	☐ No ☐ Yes	Sickle Cell Disease	☐ No ☐ Yes	Heat Illness	☐ No ☐ Yes
Heart Valve Disease	☐ No ☐ Yes	Sickle Cell Trait	☐ No ☐ Yes	Broken Bones	☐ No ☐ Yes
Heart Murmur	☐ No ☐ Yes	Easy Bleeding	☐ No ☐ Yes	Dislocated Joints	☐ No ☐ Yes
Endocarditis	☐ No ☐ Yes	**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:

Neurological Symptoms for Spinal Cord Compression and Atlanto-axial Instability

Difficulty controlling bowels or bladder	☐ No ☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No ☐ Yes
Numbness or tingling in legs, arms, hands or feet	☐ No ☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No ☐ Yes
Weakness in legs, arms, hands or feet	☐ No ☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No ☐ Yes
Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet	☐ No ☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No ☐ Yes
Head Tilt	☐ No ☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No ☐ Yes
Spasticity	☐ No ☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No ☐ Yes
Paralysis	☐ No ☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No ☐ Yes

PLEASE LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW

(includes inhalers, birth control or hormone therapy)

Medication, Vitamin or Supplement Name	*Dosage*	*Times per Day*	*Medication, Vitamin or Supplement Name*	*Dosage*	*Times per Day*	*Medication, Vitamin or Supplement Name*	*Dosage*	*Times per Day*

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

Name of Person Completing this Form	**Relationship to Athlete**	**Phone**	**Email**