PARTICIPATION PACKET
REQUIRED ITEMS CHECKLIST

Special Olympics New Jersey

PLEASE NOTE: All required boxes must be checked on this checklist in order for an athlete to be cleared for participation.

Special Olympics New Jersey

PAGE 1: Release Form

- ☐ Athlete name
- ☐ Athlete signature (IF OWN GUARDIAN)
- ☐ Date
- ☐ Parent/guardian signature (IF ATHLETE NOT OWN GUARDIAN)

PAGE 2: Emergency Medical Care Refusal Form (Athlete Completion) OR
PAGE 3: Emergency Medical Care Refusal Form (Parent/Guardian Completion)

- ☐ *Required **ONLY IF** the athlete or the parent/guardian of the athlete checks either box in item 4 on the Release Form.

PAGE 4: Athlete Medical Form - Health History
(Completed by athlete or parent/guardian/caregiver)

- ☐ Athlete first and last name
- ☐ Address
- ☐ Date of birth
- ☐ Gender

Attach Completed NJPPE Form
(Completed by a medical professional ONLY)

- ☐ Examiner has entered ANY medical physical information
- ☐ Date of exam
- ☐ Recommendations*
- ☐ Examiner clears athlete for participation
- ☐ Examiner signature/stamp
- ☐ Phone, email, AND/OR license #

Please make a copy of each page to keep for yourself before submission. Please submit the original copy.
Thank you for your interest in Special Olympics New Jersey!

Athlete Medical Form – **HEALTH HISTORY**

(to be completed by athlete or parent/guardian/caregiver)

Special Olympics New Jersey

AREA:

LOCAL TRAINING PROGRAM:

ATHLETE INFORMATION

First Name: Middle Name:

Last Name:

Date Birth *(mm/dd/yyyy)* : Female: ☐ Male: ☐

Address (Street):

Address (City, State, Zip):

Phone: Cell:

E-mail:

Eye color: Ethnicity: *(optional)*

Athlete Employer, if any:

I am my own guardian. ☐ Yes ☐ No

Does the athlete have *(check any that apply)*:

☐ Autism ☐ Down syndrome ☐ Fragile X Syndrome

☐ Cerebral Palsy ☐ Fetal Alcohol Syndrome

☐ Other syndrome, please specify:

Is the athlete allergic to any of the following *(please list)*:

☐ Latex ☐ No Known Allergies

☐ Medications:

☐ Insect Bites or Stings:

☐ Food:

List any special dietary needs:

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, select below and describe*

☐ Yes, had abnormal EKG ☐ Yes, had abnormal Echo

☐ PARENT ☐ GUARDIAN INFORMATION *(if not own guardian)*

Name:

Phone: Cell:

E-mail:

Emergency Contact Name: Same as Above: ☐

Emergency Contact Phone (cell):

Emergency Contact Relationship:

Does the athlete have a primary care physician? ☐ Yes ☐ No *If yes, list.*

Physician Name: Physician Phone:

Insurance Policy (Company and Number):

Does the athlete have any objections to emergency medical care?

☐ No ☐ Yes *If yes, contact your local Program to get the Emergency Care Refusal Form.*

List any sports the athlete wishes to play:

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

☐ No ☐ Yes *If yes, please describe:*

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

Has the athlete had a Tetanus vaccine in the past 7 years? ☐ No ☐ Yes

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:

ATTENTION PARENT/GUARDIAN: The preparticipation physical examination (page 3) must be completed by a health care provider who has completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

HE0503 9-2681/0410

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

Preparticipation Physical Evaluation

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	**No**
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

_____

_____

_____

_____

_____

Please indicate if you have ever had any of the following.

	Yes	**No**
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

NOTE: The preparticiaption physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practice nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

1. **Consider additional questions on more sensitive issues**
   - **Do you feel stressed out or under a lot of pressure?**
   - **Do you ever feel sad, hopeless, depressed, or anxious?**
   - **Do you feel safe at your home or residence?**
   - **Have you ever tried cigarettes, chewing tobacco, snuff, or dip?**
   - **During the past 30 days, did you use chewing tobacco, snuff, or dip?**
   - **Do you drink alcohol or use any other drugs?**
   - **Have you ever taken anabolic steroids or used any other performance supplement?**
   - **Have you ever taken any supplements to help you gain or lose weight or improve your performance?**
   - **Do you wear a seat belt, use a helmet, and use condoms?**
2. **Consider reviewing questions on cardiovascular symptoms (questions 5–14).**

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type)_____ Date of exam _____

Address _____ Phone _____

Signature of physician, APN, PA _____

HE0503 9-2681/0410

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

  Reason _____

Recommendations _____

_____

_____

_____

_____

_____

EMERGENCY INFORMATION

Allergies _____

_____

_____

_____

_____

_____

Other information _____

_____

_____

_____

_____

HCP OFFICE STAMP

SCHOOL PHYSICIAN:

Reviewed on _____
(Date)

Approved _____ Not Approved _____

Signature:_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) _____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____

Completed Cardiac Assessment Professional Development Module

Date_____ Signature_____

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

RELEASE FORM

Special Olympics New Jersey

I want to take part in Special Olympics and agree to the following:

1. **Able to Participate.** I am able to take part in Special Olympics. I know there is a risk of injury.

2. **Photo Release.** Special Olympics organizations may use my picture, video, name, voice, and words to promote Special Olympics.

3. **Overnight Stay.** For some events, I may stay in a hotel or someone's home. If I have questions, I will ask.

4. **Emergency Care.** If I am unable, or my guardian is unavailable, to make medical decisions in an emergency, I authorize Special Olympics to seek medical care on my behalf, unless I check 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 checked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)

5. **Health Programs.** If I take part in a health program, I consent to health activities, exams, and treatment. This should not replace regular health care. I can say no to treatment or anything else any time.

6. **Personal Information.** I understand my information may be used and shared by Special Olympics to:
   - Make sure I am eligible and can participate safely;
   - Run trainings and events and share results;
   - Put my information in a computer system;
   - Provide health treatment, make referrals, consult doctors, and remind me about follow-up services;
   - Research, share, and respond to needs of Special Olympics athletes (identifying information removed if shared publically); and
   - Protect health and safety, respond to government requests, and report information required by law.

   I can ask to see and change my information.

7. **Concussions.** I understand the risk of concussions and continuing to play sports with a concussion. I may have to get medical care if I have a suspected concussion. I also may have to wait 7 days or more and get permission from a doctor before I start playing sports again.

ATHLETE NAME: _____

ATHLETE SIGNATURE (required for athlete over 18 years old **with capacity to sign legal documents**)

I have read and understand this release. If I have questions, I will ask. By signing, I agree to this form.

Athlete Signature: _____ Date: _____

PARENT/GUARDIAN SIGNATURE (required for **athlete under 18 years old or lacking 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 COMPLETION

(To be completed by athlete signing on own behalf)

If an athlete is not his/her own guardian, please complete Page 3 instead.

Instructions: Only complete this form if you **do not consent to emergency medical care** on religious or other grounds and have checked a box under the Emergency Care provision on the Release Form.

I, _____, am a Special Olympics Athlete with capacity to sign documents on my own behalf and agree to the following:

1. **No Consent to Emergency Medical Care.** I understand that Special Olympics' standard registration form requires athletes or their parents or guardians to consent to emergency medical care for the athlete if needed in an emergency. Based on religious beliefs or other reasons I am not consenting to emergency medical care.

YOU MUST CHECK THE BOX AND WRITE YOUR INITIALS NEXT TO ONE STATEMENT TO CONFIRM YOUR INTENT:

☐ **I DO NOT CONSENT TO ANY KIND OF MEDICAL TREATMENT, EVEN IN A LIFE-THREATENING EMERGENCY. INITIALS: _____**

☐ **I DO NOT CONSENT TO BLOOD TRANSFUSIONS, EVEN IN A LIFE-THREATENING EMERGENCY. I CONSENT TO ALL OTHER KINDS OF EMERGENCY MEDICAL CARE. INITIALS: _____**

2. **Printed Instructions.** I agree to carry printed instructions that describe my religious or other objections to medical treatment and how I wish Special Olympics to respond if I get sick or hurt and cannot speak for myself. I agree to carry these printed instructions with me at all times during my participation in any Special Olympics activity, including during meal times, in overnight accommodations, at training sessions and competitions, and during travel to and from Special Olympics activities.

3. **Friend or Family Accompaniment.** I understand that I must be accompanied by an adult friend or family member in order for that person can take personal responsibility for me during a medical emergency where I am unable to speak for myself.

4. **Emergency Medical Care If Athlete Is Not Accompanied.** I understand that, if I am not carrying the printed instructions **or** the accompanying adult is not present and actively taking personal responsibility for me during a medical emergency where I am unable to speak for myself, Special Olympics may seek emergency medical care for me as recommended by medical professionals responding to the emergency.

5. **Liability Release.** I release Special Olympics, its employees, and its volunteers from all claims that may arise out of taking or failing to take measures to provide me with emergency medical care. I am agreeing to this release because I have refused, knowingly and voluntarily, to give Special Olympics permission to take emergency measures, and I am expressly withholding consent to emergency medical care on religious or other grounds.

I have read and understand this release. By signing, I agree to this release.

Athlete Signature: _____ Date: _____

By signing, I agree to accompany the Athlete during Special Olympics activities and take personal responsibility for the Athlete during an emergency. I understand the extent to which the Athlete does not consent to emergency medical care and agree to act in accordance with the Athlete's wishes as I understand them.

Signature of Accompanying Adult: _____ Date: _____

Printed Name: _____ Relationship: _____

PARENT OR GUARDIAN COMPLETION

(To be completed by parent or guardian of athlete who is under 18 years old or otherwise has a legal guardian)

Instructions: Only complete this form if you **do not consent to emergency medical care** on religious or other grounds and have checked a box under the Emergency Care provision on the Release Form.

I am the parent/guardian of _____ (the "Athlete") and agree to the following:

1. **No Consent to Emergency Medical Care.** I understand that Special Olympics' standard registration form requires athletes or their parents or guardians to consent to emergency medical care for the athlete if needed in an emergency. Based on religious beliefs or other reasons I am not consenting to emergency medical care as follows.

YOU MUST CHECK THE BOX AND WRITE YOUR INITIALS NEXT TO ONE STATEMENT TO CONFIRM YOUR INTENT:

☐ **I DO NOT CONSENT TO ANY KIND OF MEDICAL TREATMENT, EVEN IN A LIFE-THREATENING EMERGENCY. INITIALS: _____**

☐ **I DO NOT CONSENT TO BLOOD TRANSFUSIONS, EVEN IN A LIFE-THREATENING EMERGENCY. I CONSENT TO ALL OTHER KINDS OF EMERGENCY MEDICAL CARE. INITIALS: _____**

2. **Accompaniment of Athlete.** I understand that I must be present in order to take personal responsibility for the Athlete if any medical treatment is to be refused on the athlete's behalf in a medical emergency arises. This includes during meal times, in overnight accommodations, at training sessions and competitions, and during travel to and from Special Olympics activities.

3. **Emergency Medical Care If Athlete Is Not Accompanied.** I understand that, if I am not present and actively taking personal responsibility for the Athlete during a medical emergency, Special Olympics will seek emergency medical care for the athlete as recommended by medical professionals responding to the emergency.

4. **Liability Release.** On behalf of myself and the Athlete, I release Special Olympics, its employees, and its volunteers from all claims that may arise out of taking or failing to take measures to provide the Athlete with emergency medical care. I am agreeing to this release because I have refused, knowingly and voluntarily, to give Special Olympics permission to take emergency measures, and I am expressly withholding consent to emergency medical care on religious or other grounds.

I am authorized to enter into this Release on the Athlete's behalf. I have read and understand this release and have explained the contents to the Athlete as appropriate. By signing, I agree that this Release shall be binding upon me, the Athlete, and our respective heirs and legal representatives.

Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

CONCUSSON 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 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 not usually 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

Effective immediately, a participant who is suspected of sustaining a concussion in 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 whether or not a concussion is suspected. If applicable, the participant's parent or guardian should be 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) 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.