Special Olympics New Jersey

PARTICIPATION PACKET REQUIRED ITEMS CHECKLIST

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

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 laast name
- ☐ Date of birth
- ☐ Address
- ☐ Phone Number and/or Email
- ☐ Gender

Page 5: Athlete Medical Form - Health History
(Completed by athlete or parent/guardian/caregiver)

- ☐ Diagnosed with any listed conditions **OR** list of current medications.

Attach Completed NJ DDD Form
(Completed by a medical professional ONLY)

OPTIONAL

- ☐ Examiner has entered ANY medical physical information
- ☐ Examiner clears athlete for participation
- ☐ Date of exam
- ☐ Recommendations*
- ☐ 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.

REVISED 08.01.2024

RELEASE FORM

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 publicly); 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: _______________________

EMERGENCY MEDICAL CARE REFUSAL FORM

Special Olympics New Jersey

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: _______________________

Special Olympics New Jersey

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: ______________________________

Athlete Medical Form – **HEALTH HISTORY**

(pages 1 & 2 to be completed by the 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:

Athlete Medical Form – **HEALTH HISTORY**
(to be completed by athlete or parent/guardian/caregiver)

Special Olympics New Jersey

Athlete's Name: ______

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

Condition			Condition			Condition		
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						

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

Describe any past broken bones or dislocated joints *(if yes is checked for either of those fields above)*: ______

Epilepsy or any type of seizure disorder	☐ No	☐ Yes
If yes, list seizure type: ______		
If yes, had seizure during the past year?	☐ No	☐ Yes
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: ______

List any other ongoing or past medical conditions: ______

PLEASE LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW *(includes inhalers, birth control or hormone therapy)*

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

Is the athlete able to administer his or her own medications? ☐ No ☐ Yes **If female athlete, list date of last menstrual period:** ______

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

Special Olympics

CONCUSSION 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 the 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 usually not 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

A participant who is suspected of sustaining a concussion in a 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 the removal or return to play of the participant. If applicable, the participant's parent or guardian should be made 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) consecutive 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.

The Centers for Disease Control website www.cdc.gov/concussion provides additional resources relative to concussions that may be of interest to participants and their families.