ATHLETE

PARTICIPATION FORM

SPECIAL OLYMPICS USE ONLY

Athlete ID Number: _ _ _ _ _ _ _ _

Expiry Date of Form: _ _/_ _/_ _ _ _

Approved by:

_____

(Print Name)

Signature:

_____

Special Olympics Ireland is committed to protecting your privacy. This form will be processed in accordance with the Data Protection Amendment Act 2003 (Republic of Ireland) and the Data Protection Act 1998 (UK) and for the purpose of administering Special Olympics programmes. Please complete ALL sections in BLOCK CAPITALS using Black or Blue ink.

Section 1: ATHLETE PERSONAL AND PROGRAMME INFORMATION

For Surname, First name and Middle name please state as on birth certificate

Mr/Ms/Mrs/Miss

Gender **Male** ☐ **Female** ☐

First Name

Nationality

Middle Name

Height *centimetres / feet*

Surname

Weight *kilograms / stone*

Preferred First Name

Eye Colour

Date of Birth

Hair Colour

D D M M Y Y Y Y

ATHLETE'S CURRENT HOME ADDRESS

Address Line 1

Address Line 2

Address Line 3

Day Phone

City/Townland

Evening

(e.g. Ardee, Dublin 7)

County

Mobile Phone

Post Code (Northern Ireland Only)

Email _____

Name the Special Olympics AFFILIATED GROUP(s) the athlete belongs to (i.e. Club, centre, school etc) and the sport/programme the athlete does with that group?

Attach a separate sheet if there is insufficient space below to list all Affiliated Groups/Sports.

Group Name 1: _____ **Sport(s):** _____

Group Name 2: _____ **Sport(s):** _____

Group Name 3: _____ **Sport(s):** _____

Group Name 4: _____ **Sport(s):** _____

Section 2: EMERGENCY & NEXT OF KIN CONTACT DETAILS (in case of emergency)

EMERGENCY CONTACT DETAILS

First Name

Relationship to Athlete
(e.g. Spouse, Father, Mother, Brother, Sister, Guardian, Carer)

Surname

Address Line 1

Address Line 2

Address Line 3

Day Phone

City/Townland
(e.g. Ardee or Dublin 7)

Evening

Mobile Phone

Post Code (Northern Ireland Only)

Email

Please provide contact details for next of kin . If the above named person (ie emergency contact) is also the next of kin please skip to Section 3

First Name

Relationship to Athlete
(e.g. Spouse, Father, Mother, Brother, Sister, Guardian, Carer)

Surname

Address Line 1

Address Line 2

Address Line 3

Day Phone

City/Townland
(e.g. Ardee or Dublin 7)

Evening

Mobile Phone

Post Code (Northern Ireland Only)

Email

Section 3: ATHLETE'S FAMILY / GUARDIAN CONTACT DETAILS *(for communication purposes)*

This nominated family member will receive information relevant to family members from time to time.
Your details will not be passed on to any third party without your prior consent.

First Name

Relationship to Athlete
(e.g. Spouse, Father, Mother, Brother, Sister, Guardian, Carer)

Surname

Address Line 1

Address Line 2

Address Line 3

Day Phone

City/Townland
(e.g. Ardee, Dublin 7)

Evening

County

Mobile Phone

Post Code (Northern Ireland Only)

Email

Please tick here if you prefer to receive family newsletters and updates by email rather than post ☐

Section 4: ATHLETE MEDICAL RECORD

It is mandatory that all boxes 1 - 65 below are answered YES or NO by placing a tick ☑ in the relevant box below

Cardiac Problem	**Yes**	**No**
1. Myocardial Infarction	☐	☐
2. Heart Murmur	☐	☐
3. Blood Pressure	☐	☐
4. Cardiac Surgery	☐	☐
5. Angina	☐	☐

Epilepsy	**Yes**	**No**
6. Absence seizure	☐	☐
7. Tonic Clonic seizure	☐	☐
8. Status epilepticus	☐	☐
9. Frequency *(Number of seizures per month)*	_____	

Mobility	**Yes**	**No**
10. Fully Mobile	☐	☐
If not fully mobile please answer 11. and 12. below		
11. Wheelchair User	☐	☐
12. Assistance Needed	☐	☐

Kidney	**Yes**	**No**
13. Urinary Tract Infection	☐	☐
14. Cystitis	☐	☐
15. Incontinence	☐	☐

Mental Health	**Yes**	**No**
16. Depression	☐	☐
17. Manic Depression	☐	☐
18. Other, please state	☐	☐

Diabetes	**Yes**	**No**
19. Insulin Dependant	☐	☐
20. Hypoglycaemia	☐	☐
21. Hyperglycaemia	☐	☐

Bone/Joint Problems	**Yes**	**No**
22. Arthritis	☐	☐
23. Osteoporosis	☐	☐
24. Hemiparesis	☐	☐

Asthma	**Yes**	**No**
25. Status asthmaticus	☐	☐
26. Frequency *(number of seizures per month)*	_____	

Hearing Problems	**Yes**	**No**
27. Hearing Aid	☐	☐
28. Uses sign language	☐	☐
29. Other	☐	☐
If yes, please specify	_____	

Vision Problems **(excluding glasses / lenses)**	**Yes**	**No**
30. Blindness	☐	☐
31. Glaucoma	☐	☐
32. Conjuntivitis	☐	☐

Other	**Yes**	**No**
33. Head Injury	☐	☐
34. Bleeding Problems	☐	☐
35. Hypothermia	☐	☐
36. Sickle Cell	☐	☐
37. Hernia	☐	☐
38. Fainting spells	☐	☐
39. Behaviour Problems	☐	☐
40. Dentures	☐	☐
41. Pregnancy	☐	☐
42. Major surgery	☐	☐
43. Glasses / Contact Lenses	☐	☐

Allergies	**Yes**	**No**
44. Dust/Pollen	☐	☐
45. Rubber/Latex	☐	☐
46. Insects/bites/stings	☐	☐
47. Medication	☐	☐
If yes, please specify:	_____	
48. Other	☐	☐
If yes, please specify:	_____	
49. Food Allergy	☐	☐
If yes, please specify:	_____	

Dietary Restrictions	**Yes**	**No**
50. Requires special diet	☐	☐
51. Coeliac	☐	☐
52. Lactose	☐	☐
53. Diabetic	☐	☐
54. Vegetarian	☐	☐
55. No pork	☐	☐
56. Other dietary restriction	☐	☐
If yes, please specify:	_____	

Diseases and Infections	**Yes**	**No**
57. Chicken Pox	☐	☐
58. Hepatitis A	☐	☐
59. Hepatitis B	☐	☐
60. HIV / AIDS	☐	☐
61. Measles	☐	☐
62. Other contagious diseases	☐	☐
If yes, please specify:	_____	

Immunisations	**Yes**	**No**	**Unknown**
63. Measles, Mumps, Rubella	☐	☐	☐
64. Tuberculosis	☐	☐	☐
65. Tetanus*	☐	☐	☐

* Please state date of tetanus immunisation

D	D	M	M	Y	Y	Y	

Section 5: ATHLETE MEDICATION DETAILS

Does the athlete have any religious objections to medical treatment? Yes ☐ No ☐

If yes, please specify: _____

_____

Is the athlete taking any medication? Yes ☐ No ☐

If yes, please specifiy prescribed medication below, otherwise skip to Section 6.

Is the athlete self medicating? Yes ☐ No ☐

(a) Prescribed medication

Medication name:

Prescribed begin date: D D M M Y Y Y Y

Prescribed end date: D D M M Y Y Y Y

Dosage amount:

Frequency of dosage:

(b) Prescribed medication

Medication name:

Prescribed begin date: D D M M Y Y Y Y

Prescribed end date: D D M M Y Y Y Y

Dosage amount:

Frequency of dosage:

(c) Prescribed medication

Medication name:

Prescribed begin date: D D M M Y Y Y Y

Prescribed end date: D D M M Y Y Y Y

Dosage amount:

Frequency of dosage:

(d) Prescribed medication

Medication name:

Prescribed begin date: D D M M Y Y Y Y

Prescribed end date: D D M M Y Y Y Y

Dosage amount:

Frequency of dosage:

(e) Prescribed medication

Medication name:

Prescribed begin date: D D M M Y Y Y Y

Prescribed end date: D D M M Y Y Y Y

Dosage amount:

Frequency of dosage:

(f) Prescribed medication

Medication name:

Prescribed begin date: D D M M Y Y Y Y

Prescribed end date: D D M M Y Y Y Y

Dosage amount:

Frequency of dosage:

If more space is required for additional medications please photocopy this page of the form.

Section 6 Registered Medical Doctor Physical Examination

Section 6A

Please answer YES or NO by placing a tick ☑in the relevant boxes below

	Yes	No
Does the athlete have Down syndrome?	☐	☐

If the answer to the above question is **"NO"** please skip to Section 6B

If the athlete has Down syndrome, Special Olympics requires that the athlete must have a full radiological examination establishing the absence of Atlantoaxial Instability before he/she may participate in sports or events which by their nature, may result in hyperextension, radical flexion, or direct pressure on the neck or upper spine. The sports and events for which such a radiological examination is required are; equestrian sports, artistic gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, squat lift, football, and any warm-ups placing undue stress on the head and neck.

Atlantoaxial Instablity **Present** ☐ **OR** Atlantoaxial Instablity **Absent** ☐

If atlantoaxial instablity is present, please refer to the instructions contained in the Special Olympics Official General Rules book or contact Special Olympics Ireland to identify the relevant forms that must be completed for the athlete to participate in Special Olympics activities.

Section 6B

I have examined the athlete _____ named in the application, and certify, based on that examination and review of the health information contained in this application, that there is no medical evidence which would preclude the athlete's participation in Special Olympics sports.

Restrictions if any:

_____

_____

_____

Doctor's Contact Details and Signature:

Surname

Firstname

Address Line 1

Address Line 2

Address Line 3

City / Townland
(e.g. Strabane or Dublin 7)

County

Postal Code
Northern Ireland only

Telephone number (day)

Telephone number (night)

Doctor's Signature _____

Date Signed
D D M M Y Y Y Y

Official Stamp of Doctor (if applicable)

Section 7a: DECLARATION & RELEASE

_____ is physically and mentally able to participate in Special Olympics Ireland Ltd and is submitting the attached application for participation and registration. A licensed physician has reviewed the health information set forth in the attached application, and has certified, based on an independent medical examination, that there is no medical evidence which would preclude or render inadvisable this athlete's participation. It is understood that if this athlete has Down Syndrome, he/she cannot participate in sports or events which by their nature result in hyper-extension, radical flexion or direct pressure on the neck or upper spine, unless a full radiological examination establishes the absence of atlantoaxial instability. The [athlete/parent/guardian] is aware that the sports and events for which this radiological examination is required are equestrian sports, artistic gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, squat lift and football (soccer) and that failure to have such examination will preclude this athlete's participation.

The signature on this form grants permission to Special Olympics Ireland Ltd to use the athlete's likeness, name, voice and words in television, radio, film, newspapers, magazines and other media, both during and anytime after the events, and in any form, for advertising or communicating the purposes and activities of Special Olympics and/or applying for funds to support those purposes and activities.

By signing below, permission is granted for this athlete to participate in Special Olympics Healthy Athlete programme that provides individual screening assessments of health status and health care needs in the areas of vision, oral health, hearing, physical therapy and a variety of health promotion areas (height, weight, sun protection, etc). It is understood these assessments are not intended for diagnosis or treatment and that provision of these health services is not intended as a substitute or alternative to regular care that has been received in the past or that may be recommended in the future. It is also understood that this athlete should seek his/her own medical advice and assistance irrespective of the provision of these services and that Special Olympics Ireland Ltd, through the provision of these services, is not making itself responsible for the athlete's health. It is understood that information that is gathered as part of the screening process may be used in group form (anonymously) to assess and communicate the overall health needs and to develop programs to address those needs.

If a medical emergency should arise during the athlete's participation in Special Olympics Ireland Ltd sporting and non sporting activities at a time when the athlete is not able to give his/her consent or make his/her own arrangements for treatment because of his/her injuries or when the parent/guardian of the athlete (in the case where the applicant is under the age of 18) is not personally present so as to be consulted regarding the athlete's care, Special Olympics Ireland Ltd is authorised to take whatever measures it shall deem necessary to ensure that the athlete is provided with any emergency medical treatment necessary, including hospitalisation, in order to protect the athlete's health and well-being.

It is understood that this athlete's personal information will be held and processed by Special Olympics Ireland Ltd for the purpose of administering the Special Olympics Ireland Ltd in accordance with the Data Protection Amendment Act 2003 (Republic of Ireland) and the Data Protection Act 1998 (UK). This athlete's personal data will be disclosed to Special Olympics Incorporated to be included in the global census for the purpose of gathering information on Athlete/Unified Partner participation in Special Olympics sporting and non sporting activities.

DECLARATION AND RELEASE FORM CONTINUED ON NEXT PAGE

Please proceed and complete as follows

Section 7(b) If the athlete is an ADULT ATHLETE (over 18 years of age)

Part (i) Where an athlete is signing the form on their own behalf

OR

Part (ii) Where a parent/guardian or next of kin signs the form on behalf of the athlete

OR

Section 7(c) If the athlete is a MINOR ATHLETE (under 18 years of age)

Section 7(b) To be completed if the athlete is an ADULT ATHLETE (over 18yrs of age)

Only need to complete PART (i) **OR** PART (ii)

PART (i) Athlete is signing the form on their own behalf

I, _____ am at least 18 years old and have submitted the attached application for participation in Special Olympics Ireland Ltd sporting and non sporting activities.
I DECLARE that, to the best of my knowledge and belief, all the particulars given in this form are correctly stated.

I have read this paper and fully understand the provisions of the release that I am signing. I understand that by signing this paper, I am saying that I agree to the provisions of this release.

Print Name:

Signature: _____ **Date:** D D M M Y Y Y Y

WITNESS SIGNATURE

I hereby certify that I have reviewed this release with the athlete whose signature appears above. I am satisfied, based on that review, that the athlete (participant with an intellectual disability) understands this release and has agreed to its terms.

Print Name:

Signature: _____ **Date:** D D M M Y Y Y Y

State your relationship to the athlete: Family Member ☐ Carer/Guardian ☐ Other ☐ _____ If "other" state your relationship

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PART (ii) Parent/Guardian/Next of Kin is signing the form on behalf of the athlete

I am the Parent /Guardian /Next of Kin of_____ (the above mentioned athlete who wishes to participate in Special Olympics Ireland Ltd)

I represent and warrant that to the best of my knowledge the athlete is physically and mentally able to participate in Special Olympics Ireland Ltd sporting and non sporting activities and, in particular, the activities for which he/she has applied to participate, and has taken appropriate medical advice in relation to his/her participation in Special Olympics Ireland Ltd. I confirm that a licensed physician has reviewed the health information set out in the athlete's medical information (Athlete Participation Form) and has certified, based on an independent medical examination, that there is no medical evidence which would render participation inadvisable. I confirm that the athlete is able to and does understand the provisions of the above release and that I have read and fully understand the provisions of the above release. Through my signature, I am agreeing to the above provisions on my own behalf and on behalf of the athlete and I DECLARE that, to the best of my knowledge and belief, all the particulars given are correctly stated.

Print Name:

Signature: _____ **Date:** D D M M Y Y Y Y

State your relationship to the athlete: Family Member ☐ Carer/Guardian ☐ Next of Kin ☐

Section 7(c) To be completed if the athlete is a MINOR ATHLETE (an individual under the age of 18)

I am the parent/guardian/next of kin of _____, (the 'athlete') a minor on whose behalf I have submitted the attached application for participation in Special Olympics Ireland Ltd sporting and non sporting activities. I hereby represent and warrant that the athlete has my permission to participate in Special Olympics Ireland Ltd sporting and non sporting activities. I DECLARE that, to the best of my knowledge and belief, all the particulars given in this form are correctly stated.

I have read and fully understand the provisions of the above release, and have explained these provisions to the athlete. Through my signature on this release form, I am agreeing to the above provisions on my own behalf and on the behalf of the athlete named above.

Print Name:

Signature: _____ **Date:** D D M M Y Y Y Y

State your relationship to the athlete: Family Member ☐ Carer/Guardian ☐ Next of Kin ☐

Section 8 Photo

In order for you to be registered as an athlete with Special Olympics Ireland, you will need to provide us with either

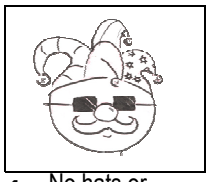
1. A colour passport quality photo OR 2. A digital image

Attach photo here

Do NOT use staples

Photo should be approximately 5cm x 4cm (about the size of this box)

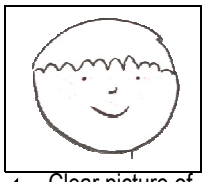
Rules to adhere to for all photographs:
* The athlete in the photograph must not be wearing a hat or sunglasses
* The photo / digital image must be from the shoulders up and the background must be clear and plain
* The photo / digital image must be of passport quality and dimensions



✗ No hats or sunglasses

✗ Eyes open, face towards camera

✗ Only one face in the picture



✔ Clear picture of athlete's face on plain background

1. A Colour Photo
If you chose this option please ensure that:
* The photo is in colour on a pale background
* Attach the photo in the space above using either glue or double sided tape
* Staples or tape that cover the photo will render it unusable
* Write clearly on the back of this photo your firstname, surname and date of birth (DD/MM/YYYY)

2. Digital Image
If you chose this option please ensure that:
* The digital image is saved in the format **LASTNAME_FIRSTNAME_DATEOFBIRTH.JPG** eg. RYAN_PAUL_251189.JPG
* The image should be 600dpi and measure approximately 5cm x 4cm (the same dimensions as a passport photograph)
* Email the digital image to **photo@specialolympics.ie**

Section 9 DECLARATION to be signed by Affiliated Group

I accept that this athlete Participation Form has been fully completed and will be submited to the Regional Office in accordance with Special Olympics Ireland registration

Affiliated Group Member: (Print name)

Signature: _____ **Date:** D D M M Y Y Y Y

Volunteer ID Number: (N/A for staff member)

State your volunteer role within the Affiliated Group:

Club Manager ☐ Volunteer Officer ☐ Athlete Protection Officer ☐ Staff member of ☐
Secretary ☐ Sports Officer ☐ Safety Officer ☐ Service/school/centre

FINAL CHECKLIST
Please tick ☑ all completed sections

Section 1: Athlete Personal & Programme Information ☐
Section 2: Emergency Contact Details ☐
Section 3: Family Contact Details (optional) ☐
Section 4: Athlete Medical Record ☐
Section 5: Athlete Medication Details ☐
Section 6: Registered Medical Doctor Physical Examination ☐
Section 7a: Declaration and Release ☐
Section 7b: Consent form for an Adult Athlete ☐
OR
Section 7c: Consent form for a Minor Athlete ☐
Section 8: Photograph attached ☐
OR Photograph emailed ☐
Section 9: You have signed it? ☐

REGIONAL CONTACT DETAILS

Well done! All you need to do now is to photocopy the form for your own records and post the **original** to the address below:

Return form to: