



# APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS ILLINOIS

Valid Application for Participation is mandatory for all competitors

605 E. Willow St. • Normal, IL 61761-2682 • 309-888-2551

SOILL Rev. 8-1-10

Area

Agency #

## ATHLETE INFORMATION

Athlete Name (last name, space, first name)

Birthdate

Agency Name

Sex (M or F)

Athlete's Mailing Address

Parent's/Guardian's (Please Circle One) Home Address

Athlete's City

Parent's/Guardian's City

State

Zip Code

State

Zip Code

Ethnicity

- White       Black/African American       Asian  
 Hispanic/Latino       Other \_\_\_\_\_

Parent's/Guardian's Home Telephone

## HEALTH INSURANCE & EMERGENCY INFORMATION (Required for Processing)

Person to be contacted

in case of emergency \_\_\_\_\_

Emergency

Contact Phone (\_\_\_\_\_) \_\_\_\_\_

Medical Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_

## PARENT AND/OR GUARDIAN AUTHORIZATION AND MEDIA RELEASE

I, on my own behalf or as the undersigned parent and/or legal guardian of the above named applicant (hereafter referred to as the "Entrant"), hereby request permission for the Entrant to participate in Special Olympics programs. I acknowledge that Special Olympics will screen all entrants using the Sex Offender Public Registry and the Child Murder and Violent Offender Against Youth Registry and understand that entrants listed on either Registry will be denied participation. I affirm that this Entrant has never been on said Registries or, if Entrant was listed on either Registry but has since been removed, I will contact Special Olympics Illinois for instructions before submitting this application.

I represent and warrant to you that the Entrant is physically and mentally able to participate in Special Olympics, and I submit herewith a subscribed medical certificate. I understand that if the 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 established the absence of Atlantoaxial Instability. I am aware that the sports and events for which this radiological examination is required are equestrian sports, artistic gymnastics, diving, pentathlon, high jump, alpine skiing, soccer, soccer skills, powerlifting squat, and butterfly stroke and diving starts in swimming.

On behalf of the Entrant and myself, I acknowledge that the Entrant will be using facilities at his/her own risk and I, on my own behalf, hereby release, discharge and indemnify Special Olympics from all liability for injury to person or damage to property of myself and Entrant.

In permitting the Entrant to participate, I am specifically granting permission to Special Olympics Illinois to use the likeness, voice and words of the Entrant in television, radio, films, newspapers, magazines and other media, and in any form not heretofore described, for the purpose of advertising or communicating the purposes and activities of Special Olympics and in appealing for funds to support such activities. I understand that by signing below I consent for the Entrant to participate in the Special Olympics Healthy Athletes Program that provides individual screening assessments of health status and health care needs. The Entrant has no obligation to participate and I understand the Entrant should seek his/her own medical advice and assistance and Special Olympics is not responsible for the Entrant's health.

If I am not personally present at Special Olympics activities in which the Entrant is to compete, so as to be consulted in case of necessity, you are authorized on my behalf and at my account to take such measures and arrange for such medical and hospital treatment as you may deem advisable for the health and well-being of the Entrant.

**I, THE UNDERSIGNED ADULT ENTRANT,** have read and fully understand the provisions of the above release and/or have had them explained. I hereby agree that I will be bound thereby and I shall defend Special Olympics Illinois and hold it harmless from disaffirmation thereof.

Entrant \_\_\_\_\_

Athlete is own guardian

Witness \_\_\_\_\_ Date \_\_\_\_\_

Athlete's Email Address \_\_\_\_\_

**I, THE UNDERSIGNED PARENT AND/OR GUARDIAN** of the above specified Entrant, have read and fully understand the provisions of the above release and have explained them to said Entrant. I hereby agree that I and said minor will be bound thereby, and I shall defend Special Olympics Illinois and hold it harmless from any disaffirmation thereof by said minor.

Signature of Parent   
and/or Legal Guardian   
(Check appropriate box)

Print Name \_\_\_\_\_ Date \_\_\_\_\_

Parent's Email Address \_\_\_\_\_

## MEDICAL CLEARANCE

### PLEASE CHECK MEDICAL INFORMATION

Does athlete have Down Syndrome?

Yes  No

If yes, have x-rays of the C1-C2 vertebrae been taken and examined?

Yes  No

Date of x-ray \_\_\_\_\_

Is the athlete clear of Atlantoaxial Instability?

Yes  No

Does the athlete have or is the athlete:

Heart Problems Yes  No

Diabetic Yes  No

Epileptic/Seizures Yes  No

Blind Yes  No

Deaf Yes  No

Hepatitis Yes  No

Other \_\_\_\_\_

Current Medication \_\_\_\_\_ Dosage \_\_\_\_\_

Allergies to medication, if any: \_\_\_\_\_

Date of last Tetanus shot: \_\_\_\_\_

I have examined the above-named Entrant and, in my opinion, there is no mental or physical reason why he or she should not participate in the Special Olympics sports training and competition program. Further information will be forwarded if required. Current medication, if any, is specified with dosage on this application.

Examination Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_

Print Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

Original parent/guardian and doctor signatures are required by the office of Special Olympics Illinois. Faxed and/or copied signatures will not be accepted.