Application for participation in Special Olympics Missouri

Physical examination required every 3 years

Care Male Female Athlete SSN	Agency Name:				Agency Number:						Rene	ewal	
Athlete's Email address				MI									
Athlete's Address (Complete) Cell Phone Cell Phone Parent/Guardian Name Parent/Guardian Rmail address Guardian Employer Parent/Guardian Email address Guardian Employer Parent/Guardian Address (Complete) City Cell Phone Pho	Gender: Male		Female	Athlete S	SN				Date of Birth				
Athlete's Address (Complete) Cell Phone Cell Phone Parent/Guardian Name Parent/Guardian Rmail address Guardian Employer Parent/Guardian Email address Guardian Employer Parent/Guardian Address (Complete) City Cell Phone Pho									 Athlete Employer				
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Parent/Guardian Address (Complete) City City Phone Cell Phone Cell Phone Cell Phone Cell Ph													
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Health Insurance Company Health History Circle One													
Heart Disease/heart defect/high blood pressure Circle One													
Near Disease Near	Health Insurance Company Medic												
1. Heart Disease/heart defect/high blood pressure	<u>Health History</u>												
2											Circl	e One	
3. Seizures/epilepsy/fainting spells	1. Heart Disease	e/hea	art defect/high	blood pressur	e Yes	No		12.	Bone or joint prob	lems	Yes	No	
1. Diabetes Yes No 15. Tobacco Use Yes No 16. Easy Bleeding Yes No No 16. Easy Bleeding Yes No No 16. Easy Bleeding Yes No No No No No No No N	2 Chest pain					No		13.	Special Diet		Yes	No	
5. Concussion or serious head injury Yes No 16. Easy Bleeding Yes No 6. Major surgery or serious illness Yes No 17. Emotional/psychiatric/behavioral Yes No 7. Heat stroke/exhaustion Yes No 18. Sickle cell trait or disease Yes No 8. Visual impairment/contact lenses/glasses Yes No 19. Immunizations up to date Yes No 9. Blind Yes No 20. Down Syndrome** Yes No 11 Deaf/Complete hearing loss Yes No 21. Intellectual Disability Yes No **athletes with Down Syndrome must complete the Atlanto-Axial Instability Assessment found on the Release form. Allergies Please print medication name, amount, date prescribed and number of times per day medication is given. Attach extra sheet of paper if needed. **I read to Move Syndrome must complete the Atlanto-Axial Instability Assessment found on the Release form. **I read to Move Syndrome must complete the Atlanto-Axial Instability Assessment found on the Release form.	3. Seizures/epile	Seizures/epilepsy/fainting spells				No		14.	Asthma		Yes	No	
6. Major surgery or serious illness Yes No 17. Emotional/psychiatric/behavioral Yes No 18. Sickle cell trait or disease Yes No 18. Sickle cell trait or disease Yes No 18. Visual impairment/contact lenses/glasses Yes No 19. Immiziations up to date Yes No 19. Immiziations up to date Yes No 10. Hearing Impaired Yes No 20. Down Syndromer* Yes No 10. Dear/Complete hearing long in Yes No 21. Autism Yes No 11. Dear/Complete hearing loss Yes No 22. Intellectual Disability Yes No 11. Dear/Complete hearing loss Yes No 22. Intellectual Disability Yes No 11. Dear/Complete hearing loss Yes No 22. Intellectual Disability Yes No 11. Dear/Complete hearing loss Yes No 22. Intellectual Disability Yes No 11. Dear/Complete hearing loss Yes No 22. Intellectual Disability Yes No 11. Dear/Complete hearing loss Yes No 22. Intellectual Disability Yes No No 11. Dear/Complete hearing loss Yes No 22. Intellectual Disability Yes No No 12. Dear/Complete Hearing Yes Yes No 22. Intellectual Disability Yes No No Yes No Yes No 22. Intellectual Disability Yes No No Yes Yes No Yes Yes No Yes Yes Yes No Yes Yes Yes No Yes Yes Yes Yes No Yes Yes Yes No Yes Yes Yes No Yes Yes Yes No Yes Yes Yes Yes No Yes		Diabetes				No		15.	Tobacco Use		Yes	No	
7. Heat stroke/exhaustion Yes No 18. Sickle cell trait or disease Yes No 19. Immunizations up to date Yes No 10 Hearing Impaired Yes No 20. DownSyndrome** Yes No 10 Hearing Impaired Yes No 21. Autism Yes No 11 Deaf/Complete hearing loss Yes No 21. Autism Yes No 11 Deaf/Complete hearing loss Yes No 22. Intellectual Disability Yes No 11 Deaf/Complete hearing loss Yes No 22. Intellectual Disability Yes No No 11 Deaf/Complete hearing loss Yes No 22. Intellectual Disability Yes No No 11 Deaf/Complete hearing loss Yes No 22. Intellectual Disability Yes No		. Concussion or serious head injury				No		16.			Yes	No	
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and certify that the athlete can participate in Special Olympics Missouri.

Updated 4.23.14