AA

APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS SOUTH DAKOTA
800 E. I-90 Lane * Sioux Falls, SD 57104 * Tele: 605.331.4117 * Fax: 605.331.4328

FORM A
Revised 08/2013

ATHLETE INFORMATION

Athlete Name (First / Last): _____

School/Delegation Name: Sioux Falls Fireworks Head of Delegation: Heather Leischner

Sex: ☐M ☐F Birth date: (MM, DD, Year) _____

Athlete Mailing Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Athlete Telephone: _____ Athlete E-Mail: _____

Ethnicity: ☐White ☐Native American ☐Black/African American ☐Hispanic ☐Other: _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name (First / Last): _____

Parent/Guardian Mailing Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Telephone: _____ E-Mail: _____

HEALTH INSURANCE & EMERGENCY INFORMATION

Health/Accident Insurance: _____ Policy Number: _____

Emergency Contact Person: _____ Emergency Contact Telephone: _____

PHYSICAL EXAM – TO BE COMPLETED BY PHYSICIAN

Examination date: _____

This physical is "good" for: ☐**3 Years** ☐**2 Years** ☐**1 Year**

Physician signature: _____

Print physician signature: _____

Address: _____

Telephone: _____

Does Athlete have Down Syndrome? ☐Yes ☐No

If yes, have x-rays of the C1-C2 vertebrae been taken? ☐Yes ☐No

Date of x-ray: _____

Is the athlete clear of Atlantoaxial Instability? ☐Yes ☐No

Date of last tetanus: _____

Allergies: ☐General ☐Medical ☐Food ☐Insect/sting

Describe allergies: _____

Check All That Apply:

- ☐ Heart disease/defect/high blood pressure
- ☐ Chest pain
- ☐ Seizures/epilepsy/fainting spells
- ☐ Diabetes
- ☐ Concussion or serious head injury
- ☐ Major surgery or illness
- ☐ Heat stroke/exhaustion
- ☐ Visually impaired/contacts/glasses
- ☐ Blind
- ☐ Hearing impaired
- ☐ Deaf/complete hearing loss
- ☐ Bone or joint problems

Current medications and dosages:

(1) _____ (2) _____

(3) _____ (4) _____

Identify all diagnosis/conditions that SOSD should be aware of in advance of this athletes participation:

Page 2 of document MUST also be completed →

AA ATHLETE OR PARENT/GUARDIAN AUTHORIZTION FOR PARTICIPATION Form A pg. 2

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" or "Athlete"), hereby give/request permission for the Entrant to participate in Special Olympics activities. I acknowledge that Special Olympics will screen all entrants using the Sex Offender Public Registry and understand that entrants listed on the Registry will be denied participation.

I represent and warrant to you that the Entrant is physically and mentally able to participate in Special Olympics. I also represent that a licensed medical professional has reviewed the health information contained in this application and has certified, based on an independent medical examination that there is no medical evidence that would preclude the Entrant from participating in Special Olympics. I understand that if the Entrant 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 the entrant or parent/guardian and two physicians have completed the official "Special Release for Athletes with Atlanto-Axial Instability," or the Entrant has had a full radiological examination, which establishes the absence of Atlanto-axial instability. I am aware that if the Entrant or the parent/guardian choose not to complete the "Special Release for Athletes with Atlanto-Axial Instability" form which establishes the absence of Atlanto-axial Instability, the Entrant must have the radiological examination before he/she can participate in judo, equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving start in swimming, high jump, alpine skiing, snowboarding, squat lift and football team competition (soccer).

I/on behalf of the Entrant, am specifically granting permission forever, to Special Olympics to use the likeness, name, voice, and words in television, radio, film, newspapers, magazines and other media, and in any form, for the purpose of publicizing, promoting or communicating the purposes and activities of Special Olympics and/or applying for funds to support those purposes and activities.

I understand that by signing below I consent to the Entrant to participate in the Special Olympics Healthy Athletes Program 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.) I understand that information gathered as part of the Healthy Athlete Program screening process may be used in group form (anonymously) to assess and communicate the overall health needs of athletes and to develop programs to address those needs. I understand that notwithstanding my consent, there is no obligation for the Athlete to participate in the Healthy Athletes Program and that either the Entrant or the parent/guardian may decide that the Athlete will not participate. I understand that provision of these health services is not intended as a substitute for regular care. I also understand that the Athlete should seek his/her own medical advice and assistance irrespective of the provision of these services and that Special Olympics through the provision of these services is not making itself responsible for Athlete's health.

I acknowledge that Special Olympics events may involve overnight activities and that the housing arrangements for each event may differ. I understand that I should contact the Special Olympics Program in my jurisdiction if I have any questions about housing arrangements for a specific event or the housing policy in general.

If an Entrant is attending a Special Olympics activity and is unable to give his/her consent for treatment, or if a medical emergency should arise when a parent/guardian is not personally present so as to be consulted regarding the Athlete's care, authorization is hereby given to Special Olympics to take whatever measures are necessary to ensure the Athlete is provided with any emergency medical treatment, including hospitalization, that Special Olympics deems advisable in order to protect the Athlete's health and well-being. (IF YOU HAVE RELIGIOUS OBJECTIONS TO RECEIVING SUCH MEDICAL TREATMENT, PLEASE CROSS OUT THIS PARAGRAPH, SIGN AND DATE.)

I, the Athlete named above, 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.

Athlete Signature: _____ **Date:** _____

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 understands this release and has agreed to its terms.

Print Name: _____ **Relationship to Athlete:** _____ **Date:** _____

I am the parent/guardian of the Athlete named in this application. 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.

I hereby give my permission for the Athlete named above to participate in Special Olympics games, recreation programs, and physical activity programs.

Parent/Guardian: _____ **Date:** _____

COMMUNITY REINVESTMENT ACT (CRA) INCOME CERTIFICATION INFORMATION

The Community Reinvestment Act holds financial institutions accountable to help meet the needs of their communities, including low- and moderate-income communities, through loans, investments and services. One of the ways financial institutions can meet these needs is through donations and volunteerism to agencies that provide services to low- and moderate-income individuals.

The information below is being requested so that Special Olympics South Dakota can qualify as a CRA eligible recipient of donations and volunteer services. By providing this information, Special Olympics South Dakota can qualify for additional funding sources.

Special Olympics South Dakota will treat the information you provide as confidential. The summary of information that is provided to financial institutions by Special Olympics South Dakota will not disclose the details you furnish below.

Do you currently utilize or qualify for any of the following services?

☐Yes ☐No Medicaid ☐Yes ☐No Rental Assistance (State or Federal Rental Assistance Program

☐Yes ☐No Food Stamps ☐Yes ☐No Free or Reduced Lunch Program

If you answered YES to **any** of the questions above, you DO NOT need to provide the information requested below.

Is your annual household Income less than $44,800?* ☐YES ☐NO (if participant is a dependent, use the parent or guardian's income)
***Annual Household Income** includes pre-tax income from all household members for employment, self-employment, child support, Social Security, BIA General Assistance. Subtract $50 per month of child support received and all child support paid.

Number of people in your household: _____