

YOUNG ATHLETES REGISTRATION



Ohio

YOUNG ATHLETES PARTICIPANT INFORMATION

Name _____

Date of Birth _____

<u>Gender</u> <input type="checkbox"/> Male <input type="checkbox"/> Female	<u>Has an Intellectual or Developmental Disability</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>T-Shirt Size</u> <input type="checkbox"/> Youth Small <input type="checkbox"/> Youth Medium <input type="checkbox"/> Youth Large
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Please mark items you would like Special Olympics to know about:

Requires Wheelchair Accessible Locations

Language Needs: _____

Medical Conditions: _____

Special Diet: _____

Other: _____

PARENT/GUARDIAN INFORMATION

Name _____

Relationship _____

Street Address _____

City _____

State/Province _____

Postal Code _____

Email _____

Phone _____

EMERGENCY CONTACT INFORMATION (other than Parent/Guardian; Parent/Guardian will be contact first in an emergency)

Contact Name _____

Relationship _____

Phone _____

SPECIAL OLYMPICS PROGRAM INFORMATION

Local Program Name _____

YOUNG ATHLETES RELEASE FORM



I am the Parent or Guardian of the Young Athletes participant named below and agree to the following:

1. **Able to Participate.** The Young Athlete is able to take part in Special Olympics. I understand there is a risk of injury.
2. **Photo Release.** Special Olympics organizations may use the Young Athlete's picture, video, name, voice, and words to promote Special Olympics.
3. **Emergency Care.** If a medical emergency should arise during the Young Athlete's participation in Special Olympics activities at a time when a parent or guardian is not present to make medical decisions, I consent to medical care for the Young Athlete if needed, unless I check one of these boxes:
 - I have a religious or other objection to the Young Athlete receiving medical treatment.
 - I consent to emergency medical care, but I do not consent to blood transfusions for the Young Athlete. (If either box is checked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)
4. **Health Programs.** If the Young Athlete takes part in a Special Olympics health program, I consent to health activities, exams, and treatment for the Young Athlete. This should not replace regular health care. I can say no to treatment or anything else any time for the Young Athlete.
5. **Personal Information.** I understand personal information may be used and shared by Special Olympics to:
 - Make sure the Young Athlete can participate safely;
 - Run trainings and events and share results;
 - Put the Young Athlete's 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 participants (identifying information removed if shared publically); and
 - Protect health and safety, respond to government requests, and report information required by law.I can ask to see and change the Young Athlete's information. I can ask to limit how the information is used.
6. **Concussions.** I understand the risk of concussions and continuing to play sports with a concussion. The Young Athlete may have to get medical care if a concussion is suspected. The Young Athlete also may have to wait 7 days or more and get permission from a doctor before they start playing sports again.

YOUNG ATHLETE NAME: _____

PARENT/GUARDIAN SIGNATURE

I am a parent or guardian of the Young Athlete. I have read and understand this form. By signing, I agree to this form on my own behalf and on behalf of the Young Athlete.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship: _____