



Special Olympics

2015-2016 Basketball Team

Sponsored by Mayfield Village



Rules for regular high school basketball will apply and all players must be capable of adhering to those rules and level of play



Who: Males and Females, minimum age of 15

Cost: FREE! Each player will receive uniform of tshirt & shorts.

Coach: Bob Beach

First Practice: Wednesday, November 11, 6:30 – 7:30 p.m. Weekly practices also on Wednesdays.

What to Wear: Non marking sole athletic shoes, tshirt, shorts & socks

Practice Location: Gilmour Academy Athletic Center, 2045 SOM Center Road, Gates Mills, Ohio, 44040.

Games: Will play other Special Olympics teams in the area.

Regional Tournament: March 4 – 6, 2016 at Lorain Community College
(some teams may have to play March 3, to be determined)

Date of State Tournament: To Be Announced

REGISTRATION DEADLINE IS Wednesday, November 4: Mail, email or personally drop off the registration form below to Mayfield Village Parks and Recreation, 6622 Wilson Mills Rd. Mayfield Village, OH, 44143, or decht@mayfieldvillage.com.

Special Olympics requires that all athletes have current "APPLICATION FOR PARTICIPATION" and "RELEASE" forms on file. They are valid for three years. A physician's signature is required on the "APPLICATION FOR PARTICIPATION" form.

REGISTRATION FORM ON BACK

REGISTRATION FORM: SPECIAL OLYMPICS BASKETBALL 2015-2016
(please print)

Athlete name: _____ Gender: male female

Athlete address: _____
(street) _____ (city) _____ (zip) _____

Athlete phone: _____ Athlete birthdate: _____ Athlete age: _____

Parent/Guardian name: _____

Parent/Guardian address: _____
(street) _____ (city) _____ (zip) _____

Parent/Guardian phone: _____ Email: _____

APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS OHIO REVISED 2009
DEMOGRAPHICS

COUNTY: _____	Date of Birth (month/day/year) _____
ORGANIZATION: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Athlete's Name _____	Athlete Home Phone # _____
Athlete's Address _____ City _____ State _____ Zip _____	Parent Primary Phone # _____ Parent Secondary Phone # _____
Parent/Guardian's Name _____ Parent/Guardian's Address (if different than athlete) _____	Primary Phone # _____ Policy # _____
Emergency Contact (if other than parent/guardian) _____ Health/Accident Insurance Company _____	

HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER

Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/> *Heart disease / heart defect / high blood pressure	<input type="checkbox"/>	<input type="checkbox"/> Allergy:
<input type="checkbox"/>	<input type="checkbox"/> *Chest pain	<input type="checkbox"/>	<input type="checkbox"/> Medicines: _____
<input type="checkbox"/>	<input type="checkbox"/> *Seizures / epilepsy/fainting spells	<input type="checkbox"/>	<input type="checkbox"/> Food: _____
<input type="checkbox"/>	<input type="checkbox"/> *Diabetes	<input type="checkbox"/>	<input type="checkbox"/> Insect stings/bites: _____
<input type="checkbox"/>	<input type="checkbox"/> *Concussion or serious head injury	<input type="checkbox"/>	<input type="checkbox"/> Special diet
<input type="checkbox"/>	<input type="checkbox"/> *Major surgery or serious illness	<input type="checkbox"/>	<input type="checkbox"/> *Asthma
<input type="checkbox"/>	<input type="checkbox"/> Heat stroke / exhaustion	<input type="checkbox"/>	<input type="checkbox"/> Tobacco use
<input type="checkbox"/>	<input type="checkbox"/> *Blindness / visual problem	<input type="checkbox"/>	<input type="checkbox"/> Easy bleeding
<input type="checkbox"/>	<input type="checkbox"/> Contact lenses / glasses	<input type="checkbox"/>	<input type="checkbox"/> Emotional / psychiatric / behavioral
<input type="checkbox"/>	<input type="checkbox"/> Hearing loss / hearing aid	<input type="checkbox"/>	<input type="checkbox"/> Sickle cell trait or disease
<input type="checkbox"/>	<input type="checkbox"/> Bone or joint problem	<input type="checkbox"/>	<input type="checkbox"/> Immunizations up to date
Other (for additional space, use back of form): _____			

Date of most recent tetanus immunization _____ / _____ / _____

(*) Requires physical examination by a physician every three (3) years

Medications:

Please print medication name, amount, date prescribed and number of times per day medication is given.

Medication Name	Dosage	Date Prescribed	Times per day	Medication Name	Dosage	Date Prescribed	Times per day

Signature of parent/caregiver/adult athlete: _____

date _____ / _____ / _____

ATLANTO-AXIAL INSTABILITY ASSESSMENT FOR ATHLETES WITH DOWN SYNDROME

EXAMINER'S NOTE: If the athlete has Down syndrome, Special Olympics requires a full radiological examination establishing the absence of Atlanto-axial 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: judo, equestrian sports, gymnastics, diving, pentathlon, butterfly stroke and diving starts in swimming, high jump, alpine skiing, snowboarding, squat lift, and football team competition (soccer).

Yes No

- Has an x-ray evaluation for atlanto-axial instability been done?
 If yes, was it positive for atlanto-axial instability? (positive indicates that the atlanto-dens interval is 5mm or more)

PHYSICAL EXAMINATION

Blood pressure: _____ / _____	Weight: _____	Height: _____	Normal/Abnormal	Normal/Abnormal	Normal/Abnormal
Normal/Abnormal	<input type="checkbox"/> Vision	<input type="checkbox"/> Respiratory system	<input type="checkbox"/> Cranial nerves		
<input type="checkbox"/>	<input type="checkbox"/> Hearing	<input type="checkbox"/> Gastrointestinal system	<input type="checkbox"/> Coordination		
<input type="checkbox"/>	<input type="checkbox"/> Oral cavity	<input type="checkbox"/> Genitourinary system	<input type="checkbox"/> Reflexes		
<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/> Skin	<input type="checkbox"/> Has Intellectual Disability		
<input type="checkbox"/>	<input type="checkbox"/> Extremities				

Other: _____

Primary Etiology/Category (If known): _____

I have reviewed the above health information and have performed the above examination on this athlete within the past 6 months and certify that the athlete can participate in Special Olympics.

RESTRICTIONS: _____

EXAMINER'S SIGNATURE: _____ Date _____ / _____ / _____

EXAMINER'S NAME: _____

ADDRESS: _____

PHONE: _____

OFFICIAL SPECIAL OLYMPICS RELEASE FORM

RELEASE TO BE COMPLETED BY ADULT ATHLETE

I, _____ am at least 18 years old and have submitted the attached application for participation in Special Olympics.

I represent and warrant that, to the best of my knowledge and belief, I am physically and mentally able to participate in Special Olympics activities. I also represent that a licensed physician has reviewed the health information contained in my application and has certified, based on an independent medical examination, that there is no medical evidence which would preclude me from participating in Special Olympics. I understand that if I have Down Syndrome, I cannot participate in sports or events which, by their nature, result in hyper-extension, radical flexion or direct pressure on my neck or upper spine unless I and two physicians have completed the official "Special Release for Athletes with Atlanto-axial Instability," available from the Special Olympics Chapter program in my state, or I have had a full radiological examination which establishes the absence of Atlanto-axial Instability. I must have the radiological examination before I can participate in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, and soccer.

Special Olympics has my permission, (both during and anytime after), to use my likeness, name voice, or words in either television, radio, film. Newspapers, magazines, and any other media, and in any form, for the purpose of advertising or communicating the purposes and activities of Special Olympics and/or applying for funds to support these purposes and activities. If, during my participation in Special Olympics activities, I should need medical treatment, and I am not able to give my consent or make my own arrangements for that treatment because of my injuries, I authorize Special Olympics to take whatever measures are necessary to protect my health and well-being, including, if necessary, hospitalization.

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.

Signature of Adult Athlete

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.

Name
(print): _____

Relationship to
athlete: _____

(e.g. family member, teacher, coach, etc.)

RELEASE TO BE COMPLETED BY PARENT OR GUARDIAN OF MINOR ATHLETE

I am the parent/guardian of _____, the minor athlete, on whose behalf I have submitted the attached application for participation in Special Olympics, I hereby represent that the athlete has my permission to participate in Special Olympics activities.

I further represent and warrant that, to the best of my knowledge and belief, the athlete is physically and mentally able to participate in Special Olympics activities. With my approval, a licensed physician has reviewed the health information set forth in the athlete's application and has certified, based on an independent medical examination, that there is no medical evidence which would preclude the athlete's participation. 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 my neck or upper spine unless I and two physicians have completed the official "Special Release for Athletes with Atlanto-axial Instability," available from the Special Olympics Chapter program in my state, or the athlete has had a full radiological examination which establishes the absence of Atlanto-axial Instability. I am aware that if I choose not to complete the "Special Release for Athletes with Atlanto-axial Instability" form which establishes the absence of Atlanto-axial Instability, the athlete must have the radiological examination before he/she can participate in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, and soccer.

In permitting the athlete to participate, I am specifically granting my permission, (both during and anytime after), to Special Olympics to use the athlete's likeness, name voice, or words in either television, radio, film. Newspapers, magazines, and any other media, and in any form, for the purpose of advertising or communicating the purposes and activities of Special Olympics and/or applying for funds to support these purposes and activities.

If a medical emergency should arise during the athlete's participation in Special Olympics activities, at a time when I am not personally present so as to be consulted regarding the athlete's care, I hereby authorize Special Olympics, on my behalf, to take whatever measures are necessary to ensure that the athlete is provided with any emergency medical treatment, including hospitalization, which Special Olympics deems advisable in order to protect the athlete's health and well-being. 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 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 programs.

Signature of Parent/Guardian

Date

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