FORM A

Revised 11/2024

ATHLETE REGISTRATION FORM

Special Olympics South Dakota

State Special Olympics Program: South Dakota **Your Delegation:** _____

Are you a new athlete to Special Olympics or Re-Registering? ☐ New Athlete ☐ Re-Registering

ATHLETE INFORMATION		
Legal Name First :	**Middle Name:**	
Legal Name Last:	**Preferred Name:**	
Date of Birth (mm/dd/yyyy):	☐ Female ☐ Male ☐ Other Gender Identity	
Race/Ethnicity (Optional): ☐ American Indian/Alaskan Native ☐ Asian American ☐ Prefer not to answer ☐ More than one race ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White or Caucasian ☐ Hispanic or Latinx		
Language(s) Spoken in Athlete's Home (Optional): Check all that apply ☐ English ☐ Spanish ☐ Other (please List):		
Street Address:		
City:	**State:**	**Zip Code:**
Phone:	**E-mail:**	
Sports/Activities:		
Athlete Employer, if any (Optional):		
Does the athlete have the capacity to consent to medical treatment on his or her own behalf? ☐ Yes ☐ No		
PARENT / GUARDIAN INFORMATION (required if minor or otherwise has a legal guardian)		
Name:		
Relationship:		
☐ **Same Contact Info as Athlete**		
Street Address:		
City:	**State:**	**Zip Code:**
Phone:	**E-mail:**	
EMERGENCY CONTACT INFORMATION		
☐ **Same as Parent/Guardian**		
Name:		
Phone:	**Relationship:**	
PHYSICIAN & INSURANCE INFORMATION		
Physician Name:		
Physician Phone:		
Insurance Company:	**Insurance Policy Number:**	
Insurance Group Number:		

FORM B

ATHLETE RELEASE FORM

Special Olympics South Dakota

I agree to the following:

1. **Ability to Participate.** I am physically able to take part in Special Olympics activities.
2. **Likeness Release.** I give permission to Special Olympics, Inc., Special Olympics games organizing committees, and Special Olympics accredited Programs (collectively "Special Olympics") to use my likeness, photo, video, name, voice, and words to promote Special Olympics and raise funds for Special Olympics.
3. **Risk of Concussion and Other Injury.** I know there is a risk of injury. I understand the risk of continuing to play sports with or after a concussion or other injury. I may have to get medical care if I have a suspected concussion or other injury. I also may have to wait 7 days or more and get permission from a doctor before I start playing sports again.
4. **Emergency Care.** If I am unable, or my guardian is unavailable, to consent or make medical decisions in an emergency, I authorize Special Olympics to seek medical care on my behalf, unless I mark one of these boxes:
   - ☐ I have a religious or other objection to receiving medical treatment. (Not common.)
   - ☐ I do not consent to blood transfusions. (Not common.)

   (If either box is marked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)
5. **Overnight Stay.** For some events, I may stay in a hotel or someone's home. If I have questions, I will ask.
6. **Health Programs.** If I take part in a health program, I consent to health activities, screenings, and treatment. This should not replace regular health care. I can say no to treatment or anything else at any time.
7. **Personal Information.** I understand that Special Olympics will be collecting my personal information as part of my participation, including my name, image, address, telephone number, health information, and other personally identifying and health related information I provide to Special Olympics ("personal information").
   - I agree and consent to Special Olympics:
     - using my personal information in order to: make sure I am eligible and can participate safely; run trainings and events; share competition results (including on the Web and in news media); provide health treatment if I participate in a health program; analyze data for the purposes of improving programming and identifying and responding to the needs of Special Olympics participants; perform computer operations, quality assurance, testing, and other related activities; and provide event-related services.
     - using my contact information to communicate with me about Special Olympics.
     - sharing my personal information with (i) researchers such as universities and public health agencies that are studying intellectual disabilities and the impact of Special Olympics activities, (ii) medical professionals in an emergency, and (iii) government authorities for the purpose of assisting me with any visas required for international travel to Special Olympics events and for any other purpose necessary to protect public safety, respond to government requests, and report information as required by law.
   - I have the right to ask to see my personal information or to be informed about the personal information that is processed about me. I have the right to ask to correct and delete my personal information, and to restrict the processing of my personal information if it is inconsistent with this consent.
   - *Privacy Policy*. Personal Information. Personal information may be shared consistent with this form and as further explained in the Special Olympics privacy policy at www.SpecialOlympics.org/Privacy-Policy
8. **Likeness Release for Sponsors.** Special Olympics relies on sponsors and partners to help support our mission. We often use photos, videos and stories of our athletes to show the impact of support by companies that sponsor Special Olympics. If you wish to allow your likeness to be used in this way, please read and sign below. I agree to the following:
   - I give permission to Special Olympics, Inc., Special Olympics games organizing committees, and Special Olympics accredited Programs (collectively "Special Olympics") and their sponsors and partners to use my likeness, photo, video, name, voice, and words ("my likeness") to acknowledge the sponsors' and partners' support for Special Olympics.
   - Special Olympics and its sponsors and partners will not use my Likeness to endorse commercial products or services.
   - I understand I will not be compensated for the use of my Likeness.

Athlete Name:	**E-mail:**
ATHLETE SIGNATURE (required for adult athlete with capacity to sign legal documents)	
I have read and understand this form. If I have questions, I will ask. By signing, I agree to this form.	
Athlete Signature:	**Date:**
PARENT/GUARDIAN SIGNATURE (required for athlete who is a minor or lacks capacity to sign legal documents)	
I am a parent or guardian of the athlete. I have read and understand this form and have explained the contents to the athlete as appropriate. By signing, I agree to this form on my own behalf and on behalf of the athlete.	
Parent/Guardian Signature:	**Date:**
Printed Name:	**Relationship:**

FORM C
Revised 12/22

COMMUNITY REINVESTMENT ACT
INCOME CERTIFICATION INFORMATION

Special Olympics South Dakota

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

Athlete Name: _____ Date: _____

FORM N
Revised 11/2024

COMMUNICABLE DISEASE WAIVER AND RELEASE OF LIABILITY, ASSUMPTION OF RISK AND INDEMNIFICATION AGREEMENT
("Agreement") for SPECIAL OLYMPICS

In consideration of being allowed to participate in any way in Special Olympics sports training, competition or fundraising activities, the undersigned acknowledges, appreciates, and agrees that:

Participation includes possible exposure to and illness from infectious and/or communicable diseases including but not limited to MRSA, influenza, and COVID-19. While particular rules and personal discipline may reduce this risk, the risk of serious illness and death does exist; and,

1. I KNOWINGLY AND FREELY ASSUME ALL SUCH RISKS, both known and unknown, EVEN IF ARISING FROM THE NEGLIGENCE OF THE RELEASEES or others, and assume full responsibility for my participation; and,

2. I willingly agree to comply with the stated and customary terms and conditions for participation as regards protection against infectious diseases. If, however, I observe and any unusual or significant hazard during my presence or participation, I will remove myself from participation and bring such to the attention of the nearest official immediately; and,

3. I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, HEREBY RELEASE AND HOLD HARMLESS Special Olympics, Inc, Special Olympics South Dakota, their officers, officials, agents, and/or employees, other participants, sponsoring agencies, sponsors, advertisers, and if applicable, owners and lessors of premises used to conduct the event ("RELEASEES"), WITH RESPECT TO ANY AND ALL ILLNESS, DISABILITY, DEATH, or loss or damage to person or property, WHETHER ARISING FROM THE NEGLIGENCE OF RELEASEES OR OTHERWISE, to the fullest extent permitted by law.

I HAVE READ THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

Name of Participant: _____

Participant Signature: _____

Date Signed: _____

FOR PARTICIPANTS OF MINORITY AGE (UNDER AGE 18 AT THE TIME OF REGISTRATION) AND PARTICIPANTS WITH A LEGAL GUARDIAN

This is to certify that I, as parent/guardian, with legal responsibility for this participant, have read and explained the provisions in this waiver/release to my child/ward including the risks of presence and participation and his/her personal responsibilities for adhering to the rules and regulations for protection against communicable diseases. Furthermore, my child/ward understands and accepts these risks and responsibilities. I for myself, my spouse, and child/ward do consent and agree to his/her release provided above for all the Releasees and myself, my spouse, and child/ward do release and agree to indemnify and hold harmless the Releasees for any and all liabilities incident to my minor child's/ward's presence or participation in these activities as provided above, EVEN IF ARISING FROM THEIR NEGLIGENCE, to the fullest extent provided by law.

Name of Parent/Guardian: _____

Parent/Guardian Signature: _____

Date Signed: _____

Athlete Medical Form

FORM Y

Special Olympics

To be completed by the athlete or parent/guardian/caregiver and brought to exam.

First name: _____ Last name: _____ Preferred name: _____

Date of birth (mm/dd/yyyy): ____/____/_____ Gender: Female ☐ Male ☐ Other ☐

Email: _____ Phone number: _____ Mobile ☐ Landline ☐

Postal address: _____ Country: _____

Emergency Contact -

First name: _____ Last name: _____ Phone number: _____ Mobile ☐ Landline ☐

Relationship to athlete: Parent/guardian ☐ Caregiver ☐ Family member ☐ Healthcare provider ☐ Coach ☐ Other ☐

Qualifying and Associated Conditions - *Check all that apply:*

Associated Conditions	Autism ☐ Cerebral Palsy ☐ Down Syndrome ☐ Epilepsy ☐ Fragile X Syndrome ☐ Fetal Alcohol Syndrome ☐ Spina Bifida ☐ Marfan Syndrome ☐ Other ☐ None ☐
Please specify other known intellectual disability diagnoses	

Assistive Devices and Accommodations - *Do you use any of the following? (Check all that apply):*

Mobility	Walker ☐ Braces or crutches ☐ Wheelchair ☐ Prosthetics ☐ Removable orthotics ☐ None ☐
Lifestyle Aids	CPAP ☐ Colostomy ☐ Dentures ☐ Inhaler ☐ Glasses, contact lenses, or protective eyewear ☐ None ☐
Communications	Hearing aid ☐ Communication devices ☐ Sign language ☐ None ☐
Medical Devices	Implantable cardioverter defibrillator (ICD) ☐ Implantable device for seizure management ☐ VP shunt ☐ Spinal cord stimulator ☐ Pacemaker ☐ None ☐

List specific dietary requirements	
Other assistive devices and accommodations	

General Health Questions - *Have you ever been diagnosed with or experienced any of the following?*

High blood pressure	Yes ☐	No ☐	Heat illness	Yes ☐	No ☐
Cardiac condition	Yes ☐	No ☐	Coeliac disease	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Enlarged spleen	Yes ☐	No ☐
Kidney disease	Yes ☐	No ☐	Hearing impairment	Yes ☐	No ☐
Bleeding disorder	Yes ☐	No ☐	Visual impairment	Yes ☐	No ☐
Anemia	Yes ☐	No ☐	Osteoporosis	Yes ☐	No ☐
Asthma	Yes ☐	No ☐	Non-verbal	Yes ☐	No ☐
Have you ever had a head injury or concussion?				Yes ☐	No ☐
Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?				Yes ☐	No ☐
Has any family member or relative died of heart problems or of sudden death before age 50?				Yes ☐	No ☐
Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?				Yes ☐	No ☐
Have you had COVID-19?				Yes ☐	No ☐
Have you been immunized for COVID-19?				Yes ☐	No ☐

Do you have an allergy to any of the following?	Dust ☐ Food ☐ Insects ☐ Animals ☐ Plants ☐ Grasses ☐ Pollen ☐ Drugs or medicine ☐ Latex ☐ Other ☐ None ☐
Please specify allergies	

Have you had any surgeries?	Yes ☐	No ☐	If yes, please list all:
Did you ever have an abnormal Electrocardiogram (EKG) or Echocardiogram (ECHO)?	Yes ☐	No ☐	If yes, please specify:
Has a doctor ever limited your participation in sports?	Yes ☐	No ☐	If yes, please specify:
Do you have epilepsy or any type of seizure disorder?	Yes ☐	No ☐	If yes, please specify:
Have you had any broken bones or dislocated joints?	Yes ☐	No ☐	If yes, please specify:
Do you have liver disease?	Yes ☐	No ☐	If yes, please specify:
Do you have lung disease?	Yes ☐	No ☐	If yes, please specify:
Do you have heart disease?	Yes ☐	No ☐	If yes, please specify:
Do you have behavioral, mental health, and/or sensory conditions?	Yes ☐	No ☐	If yes, please specify:

Medication and Treatment - *Please list:*

Are you taking any prescription or over-the-counter medications or treatments? (Including birth control pills, insulin, multivitamins, allergy shots or pills, asthma inhalers, epilepsy medication, anti-inflammatory medication, supplements of any kind. etc.) Please list:

Medication, Vitamin, or Supplement Name	Dosage	Times per day

Medication, Vitamin, or Supplement Name	Dosage	Times per day

Eligibility to participate
Every person with an intellectual disability who is at least eight years of age is eligible to participate in Special Olympics. A person is considered to have an intellectual disability for purposes of determining his or her eligibility to participate in Special Olympics if that person satisfies any one of the following requirements: (1) The person has been identified by an agency or professional as having an intellectual disability as determined by their localities; or (2) The person has a cognitive delay, as determined by standardized measures such as intelligent quotient or "IQ" testing or other measures which are generally accepted within the professional community in that Accredited Program's nation as being a reliable measurement of the existence of a cognitive delay; or (3) The person has a closely related developmental disability. A "closely related developmental disability" means having functional limitations in both general learning (such as IQ) and in adaptive skills (such as in recreation, work, independent living, self-direction, or self-care). However, persons whose functional limitations are based solely on a physical, behavioral, or emotional disability, or a specific learning or sensory disability, are not eligible to participate as Special Olympics athletes, but may be eligible to volunteer for Special Olympics.

Today's date (mm/dd/yyyy): _____/_____/_____

Signature of person completing the form: _____

Is this form being completed by someone other than the athlete? Yes ☐ No ☐

If form is being completed by someone other than the athlete, please select the relationship to athlete.

Relationship to athlete: Parent/guardian ☐ Caregiver ☐ Family member ☐ Healthcare provider ☐ Coach ☐ Other ☐

MEDICAL PHYSICAL INFORMATION (TO BE COMPLETED BY EXAMINER ONLY) FORM Z

To be completed by a Licensed Medical Professional qualified to conduct physical exams and prescribe medications. If necessary, please use additional pages to list anything else Special Olympics should know about this athlete.

Athlete first and last name: _____ Date of birth (mm/dd/yyyy): ____/____/_____

Height (in/cm)	Weight (lb/kg)	Waist circumference (in/cm)	Temperature (°F/°C)	Pulse (bpm)	O2Sat (%)	Blood pressure (mmHG)		Vision (out of 20)	
						systolic	diastolic	os	od

Medical			
Eyes, ears, nose, and throat: include pupils, hearing	Normal ☐	Abnormal ☐	Findings:
Heart: include murmurs (auscultation standing, auscultation supine, and ± valsalva maneuver)	Normal ☐	Abnormal ☐	Findings:
Lungs	Normal ☐	Abnormal ☐	Findings:
Abdomen	Normal ☐	Abnormal ☐	Findings:
Skin: HSV, MRSA, or tinea corporis	Normal ☐	Abnormal ☐	Findings:
Neurological	Normal ☐	Abnormal ☐	Findings:
Musculoskeletal			
Neck	Normal ☐	Abnormal ☐	Findings:
Back	Normal ☐	Abnormal ☐	Findings:
Shoulder and arm	Normal ☐	Abnormal ☐	Findings:
Elbow and forearm	Normal ☐	Abnormal ☐	Findings:
Wrist, hand, and fingers	Normal ☐	Abnormal ☐	Findings:
Hip and thigh	Normal ☐	Abnormal ☐	Findings:
Knee	Normal ☐	Abnormal ☐	Findings:
Lower leg and ankle	Normal ☐	Abnormal ☐	Findings:
Foot and toes	Normal ☐	Abnormal ☐	Findings:

MEDICAL ELIGIBILITY FOR SPORT *(TO BE COMPLETED BY EXAMINER ONLY)*

Licensed Medical Examiners: It is recommended that the examiner review items on the medical history with the athlete or their guardian, prior to performing the physical exam. If an athlete needs further medical evaluation, please provide information regarding the licensed healthcare provider below. That provider should complete a referral below and second physician for referral should complete page 4.

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of: _____

☐ Not medically eligible pending further evaluation of: _____

☐ Not medically eligible to participate in the following sports: _____

☐ Not medically eligible for any sports

I have examined the athlete named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date (mm/dd/yyyy): ____/____/_____

Address: _____ Phone: _____

Signature of health care professional: _____

NPI or License number: _____ License type (MD, DO, NP, or PA): _____