# ATHLETE REGISTRATION FORM

Special Olympics

**State Special Olympics Program:**_____ **Local Area/Delegation:**_____

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

| **ATHLETE INFORMATION** | | |
|---|---|---|
| **First Name:** | **Middle Name:** | |
| **Last Name:** | **Preferred Name:** | |
| **Date of Birth (mm/dd/yyyy):** | ☐ Female ☐ Male ☐ Other Gender Identity | |
| **Race/Ethnicity:** ☐ Prefer not to answer<br>☐ American Indian/Alaskan Native ☐ Asian American ☐ More than one race<br>☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander<br>☐ White or Caucasian ☐ Hispanic or Latinx | | |
| **Language(s) Spoken in Athlete's Home (Optional):** Check all that apply<br>☐ 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:** | | |

# ATHLETE RELEASE FORM

**Special Olympics**

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, words, and biographical information 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 for communicating with me about Special Olympics.
     - sharing my personal information confidentially 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 may be used and shared consistent with this form and as further explained in the Special Olympics privacy policy at www.SpecialOlympics.org/Privacy-Policy.

| | |
|---|---|
| **Athlete Name:** | |
| **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:** |

# Athlete Medical Form – **HEALTH HISTORY**

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

Special Olympics

**Athlete First & Last Name:**_____ **Preferred Name:**_____

**Athlete Date of Birth** (mm/dd/yyyy):_____ ☐ Female ☐ Male

**STATE PROGRAM:**_____ **E-mail:**_____

**ASSOCIATED CONDITIONS - Does the athlete have** *(check any that apply)*:

☐ Autism ☐ Down Syndrome ☐ Fragile X Syndrome

☐ Cerebral Palsy ☐ Fetal Alcohol Syndrome

☐ Other Syndrome, please specify:_____

**ALLERGIES & DIETARY RESTRICTIONS**

☐ No Known Allergies

☐ Latex

☐ Medications:_____

☐ Insect Bites or Stings:_____

☐ Food:_____

**ASSISTIVE DEVICES - Does the athlete use** *(check any that apply)*:

| | | |
|---|---|---|
| ☐ Brace | ☐ Colostomy | ☐ Communication Device |
| ☐ C-PAP Machine | ☐ Crutches or Walker | ☐ Dentures |
| ☐ Glasses or Contacts | ☐ G-Tube or J-Tube | ☐ Hearing Aid |
| ☐ Implanted Device | ☐ Inhaler | ☐ Pacemaker |
| ☐ Removable Prosthetics | ☐ Splint | ☐ Wheel Chair |

**List any special dietary needs:**

## SPORTS PARTICIPATION

**List all Special Olympics sports the athlete wishes to play:**

**Has a doctor ever limited the athlete's participation in sports?**
☐ No ☐ Yes *If yes, please describe:*

## SURGERIES, INFECTIONS, VACCINES

**List all past surgeries:**

**Does the athlete currently have any chronic or acute infection?**
☐ No ☐ Yes *If yes, please describe:*

**Has the athlete ever had an abnormal Electrocardiogram (EKG) or Echocardiogram (Echo)?** *If yes, describe date and results*
☐ Yes, had abnormal EKG
☐ Yes, had abnormal Echo

**Has the athlete had a Tetanus vaccine in the past 7 years?** ☐ No ☐ Yes

## EPILEPSY AND/OR SEIZURE HISTORY

**Epilepsy or any type of seizure disorder** ☐ No ☐ Yes

*If yes, list seizure type:*_____

*If yes, had seizure during the past year?* ☐ No ☐ Yes

## MENTAL HEALTH

| | | | | | |
|---|---|---|---|---|---|
| **Self-injurious behavior during the past year** | ☐ No | ☐ Yes | **Depression** *(diagnosed)* | ☐ No | ☐ Yes |
| **Aggressive behavior during the past year** | ☐ No | ☐ Yes | **Anxiety** *(diagnosed)* | ☐ No | ☐ Yes |

**Describe any additional mental health concerns:**

## FAMILY HISTORY

**Has any relative died of a heart problem before age 50?** ☐ No ☐ Yes

**Has any family member or relative died while exercising?** ☐ No ☐ Yes

**List all medical conditions that run in the athlete's family:**

# Athlete Medical Form – **HEALTH HISTORY**

**(To be completed by the athlete or parent/guardian/caregiver and brought to Exam)**

**Athlete's First and Last Name:**_____

| HAS THE ATHLETE EVER BEEN DIAGNOSED WITH OR EXPERIENCED ANY OF THE FOLLOWING CONDITIONS | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Loss of Consciousness | ☐ No | ☐ Yes | High Blood Pressure | ☐ No | ☐ Yes | Stroke/TIA | ☐ No | ☐ Yes |
| Dizziness during or after exercise | ☐ No | ☐ Yes | High Cholesterol | ☐ No | ☐ Yes | Concussions | ☐ No | ☐ Yes |
| Headache during or after exercise | ☐ No | ☐ Yes | Vision Impairment | ☐ No | ☐ Yes | Asthma | ☐ No | ☐ Yes |
| Chest pain during or after exercise | ☐ No | ☐ Yes | Hearing Impairment | ☐ No | ☐ Yes | Diabetes | ☐ No | ☐ Yes |
| Shortness of breath during or after exercise | ☐ No | ☐ Yes | Enlarged Spleen | ☐ No | ☐ Yes | Hepatitis | ☐ No | ☐ Yes |
| Irregular, racing or skipped heart beats | ☐ No | ☐ Yes | Single Kidney | ☐ No | ☐ Yes | Urinary Discomfort | ☐ No | ☐ Yes |
| Congenital Heart Defect | ☐ No | ☐ Yes | Osteoporosis | ☐ No | ☐ Yes | Spina Bifida | ☐ No | ☐ Yes |
| Heart Attack | ☐ No | ☐ Yes | Osteopenia | ☐ No | ☐ Yes | Arthritis | ☐ No | ☐ Yes |
| Cardiomyopathy | ☐ No | ☐ Yes | Sickle Cell Disease | ☐ No | ☐ Yes | Heat Illness | ☐ No | ☐ Yes |
| Heart Valve Disease | ☐ No | ☐ Yes | Sickle Cell Trait | ☐ No | ☐ Yes | Broken Bones | ☐ No | ☐ Yes |
| Heart Murmur | ☐ No | ☐ Yes | Easy Bleeding | ☐ No | ☐ Yes | Dislocated Joints | ☐ No | ☐ Yes |
| Endocarditis | ☐ No | ☐ Yes | **If female athlete, list date of last menstrual period:**_____ | | | | | |

**Describe any past broken bones or dislocated joints** *(if yes is checked for either of those fields above)*:

**List any other ongoing or past medical conditions:**

| Neurological Symptoms for Spinal Cord Compression and Atlanto-axial Instability | | | | | |
|---|---|---|---|---|---|
| **Difficulty controlling bowels or bladder** | ☐ No | ☐ Yes | *If yes, is this new or worse in the past 3 years?* | ☐ No | ☐ Yes |
| **Numbness or tingling in legs, arms, hands or feet** | ☐ No | ☐ Yes | *If yes, is this new or worse in the past 3 years?* | ☐ No | ☐ Yes |
| **Weakness in legs, arms, hands or feet** | ☐ No | ☐ Yes | *If yes, is this new or worse in the past 3 years?* | ☐ No | ☐ Yes |
| **Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet** | ☐ No | ☐ Yes | *If yes, is this new or worse in the past 3 years?* | ☐ No | ☐ Yes |
| **Head Tilt** | ☐ No | ☐ Yes | *If yes, is this new or worse in the past 3 years?* | ☐ No | ☐ Yes |
| **Spasticity** | ☐ No | ☐ Yes | *If yes, is this new or worse in the past 3 years?* | ☐ No | ☐ Yes |
| **Paralysis** | ☐ No | ☐ Yes | *If yes, is this new or worse in the past 3 years?* | ☐ No | ☐ Yes |

**PLEASE LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW**

*(includes inhalers, birth control or hormone therapy)*

| *Medication, Vitamin or Supplement Name* | *Dosage* | *Times per Day* | *Medication, Vitamin or Supplement Name* | *Dosage* | *Times per Day* | *Medication, Vitamin or Supplement Name* | *Dosage* | *Times per Day* |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

Is the athlete able to administer his or her own medications? ☐ No ☐ Yes

**Name of Person Completing this Form** **Relationship to Athlete** **Phone** **Email**

# Athlete Medical Form – **PHYSICAL EXAM**

**(To be completed by a Licensed Medical Professional qualified to conduct exams & prescribe medications)**

**Athlete's First and Last Name:** _____

## MEDICAL PHYSICAL INFORMATION

*(To be completed by a Licensed Medical Professional qualified to conduct physical exams and prescribe medications)*

| Height | Weight | BMI *(optional)* | Temperature | Pulse | $O_2$Sat | Blood Pressure (in mmHg) | | Vision |
|---|---|---|---|---|---|---|---|---|
| cm | kg | BMI | C | | | BP Right: | BP Left: | Right Vision 20/40 or better ☐ No ☐ Yes ☐ N/A |
| in | lbs | Body Fat % | F | | | | | Left Vision 20/40 or better ☐ No ☐ Yes ☐ N/A |

| | | | | | |
|---|---|---|---|---|---|
| Right Hearing (Finger Rub) | ☐ Responds | ☐ No Response | ☐ Can't Evaluate | | |
| Left Hearing (Finger Rub) | ☐ Responds | ☐ No Response | ☐ Can't Evaluate | | |
| Right Ear Canal | ☐ Clear | ☐ Cerumen | ☐ Foreign Body | | |
| Left Ear Canal | ☐ Clear | ☐ Cerumen | ☐ Foreign Body | | |
| Right Tympanic Membrane | ☐ Clear | ☐ Perforation | ☐ Infection | ☐ NA | |
| Left Tympanic Membrane | ☐ Clear | ☐ Perforation | ☐ Infection | ☐ NA | |
| Oral Hygiene | ☐ Good | ☐ Fair | ☐ Poor | | |
| Thyroid Enlargement | ☐ No | ☐ Yes | | | |
| Lymph Node Enlargement | ☐ No | ☐ Yes | | | |
| Heart Murmur (supine) | ☐ No | ☐ 1/6 or 2/6 | ☐ 3/6 or greater | | |
| Heart Murmur (upright) | ☐ No | ☐ 1/6 or 2/6 | ☐ 3/6 or greater | | |
| Heart Rhythm | ☐ Regular | ☐ Irregular | | | |
| Lungs | ☐ Clear | ☐ Not clear | | | |
| Right Leg Edema | ☐ No | ☐ 1+ ☐ 2+ | ☐ 3+ ☐ 4+ | | |
| Left Leg Edema | ☐ No | ☐ 1+ ☐ 2+ | ☐ 3+ ☐ 4+ | | |
| Radial Pulse Symmetry | ☐ Yes | ☐ R>L | ☐ L>R | | |
| Cyanosis | ☐ No | ☐ Yes, describe | | | |
| Clubbing | ☐ No | ☐ Yes, describe | | | |

| | | | | | |
|---|---|---|---|---|---|
| Bowel Sounds | ☐ Yes | ☐ No | | | |
| Hepatomegaly | ☐ No | ☐ Yes | | | |
| Splenomegaly | ☐ No | ☐ Yes | | | |
| Abdominal Tenderness | ☐ No | ☐ RUQ | ☐ RLQ | ☐ LUQ | ☐ LLQ |
| Kidney Tenderness | ☐ No | ☐ Right | ☐ Left | | |
| Right upper extremity reflex | ☐ Normal | ☐ Diminished | ☐ Hyperreflexia | | |
| Left upper extremity reflex | ☐ Normal | ☐ Diminished | ☐ Hyperreflexia | | |
| Right lower extremity reflex | ☐ Normal | ☐ Diminished | ☐ Hyperreflexia | | |
| Left lower extremity reflex | ☐ Normal | ☐ Diminished | ☐ Hyperreflexia | | |
| Abnormal Gait | ☐ No | ☐ Yes, describe below | | | |
| Spasticity | ☐ No | ☐ Yes, describe below | | | |
| Tremor | ☐ No | ☐ Yes, describe below | | | |
| Neck & Back Mobility | ☐ Full | ☐ Not full, describe below | | | |
| Upper Extremity Mobility | ☐ Full | ☐ Not full, describe below | | | |
| Lower Extremity Mobility | ☐ Full | ☐ Not full, describe below | | | |
| Upper Extremity Strength | ☐ Full | ☐ Not full, describe below | | | |
| Lower Extremity Strength | ☐ Full | ☐ Not full, describe below | | | |
| Loss of Sensitivity | ☐ No | ☐ Yes, describe below | | | |

## SPINAL CORD COMPRESSION & ATLANTO-AXIAL INSTABILITY (AAI) *(Select one)*

☐ **Athlete shows NO EVIDENCE of neurological symptoms or physical findings associated with spinal cord compression or atlanto-axial instability.**

**OR**

☐ **Athlete has neurological symptoms or physical findings that could be associated with spinal cord compression or atlanto-axial instability and must receive an additional neurological evaluation to rule out additional risk of spinal cord injury prior to clearance for sports participation.**

## ATHLETE CLEARANCE TO PARTICIPATE (*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 make a referral below and second physician for referral should complete page 4.*

☐ **This athlete is ABLE to participate in Special Olympics sports without restrictions.**

☐ **This athlete is ABLE to participate in Special Olympics sports WITH restrictions. Describe →** _____

☐ **This athlete MAY NOT participate in Special Olympics sports at this time & MUST be further evaluated by a physician for the following concerns:**

☐ Concerning Cardiac Exam ☐ Acute Infection ☐ $O_2$ Saturation Less than 90% on Room Air

☐ Concerning Neurological Exam ☐ Stage II Hypertension or Greater ☐ Hepatomegaly or Splenomegaly

☐ Other, please describe:

## Additional Licensed Examiner's Notes and Recommended (but not required) Follow-up:

☐ Follow up with a cardiologist ☐ Follow up with a neurologist ☐ Follow up with a primary care physician

☐ Follow up with a vision specialist ☐ Follow up with a hearing specialist ☐ Follow up with a dentist or dental hygienist

☐ Follow up with a podiatrist ☐ Follow up with a physical therapist ☐ Follow up with a nutritionist

☐ Other/Exam Notes:

| | | |
|---|---|---|
| | | Name: |
| | | E-mail: |
| **Signature of Licensed Medical Examiner** | Exam Date | Phone: License #: |

# Athlete Medical Form – **MEDICAL REFERRAL FORM**

**(To be completed by a Licensed Medical Professional only if referral is needed)**

**Athlete's First and Last Name:**_____

**This page only needs to be completed and signed if the physician on page three does not clear the athlete and indicates further evaluation is required.**

**Athlete should bring the previously completed pages to the appointment with the specialist.**

Examiner's Name:_____

Specialty:_____

I have been asked to perform an additional athlete exam for the following medical concern(s) - *Please describe:*

☐ Concerning Cardiac Exam ☐ Acute Infection ☐ $O_2$ Saturation Less than 90% on Room Air

☐ Concerning Neurological Exam ☐ Stage II Hypertension or Greater ☐ Hepatomegaly or Splenomegaly

☐ Other, please describe:

**In my professional opinion, this athlete MAY now participate in Special Olympics sports (indicate restrictions or limitations below):**

☐ **Yes** ☐ **Yes, but with restrictions** ***(list below)*** ☐ **No**

Additional Examiner Notes/Restrictions:

Examiner E-mail: _____

Examiner Phone: _____

License: _____

**Examiner's Signature** **Date**

**This section to be completed by Special Olympics staff only, if applicable.**

This medical exam was completed at a MedFest event? ☐ Yes ☐ No

The athlete is a Unified Partner or a Young Athlete Participant? ☐ Unified Partner ☐ Young Athlete

Special Olympics Michigan

**Educational Material for Parents/Legal Guardians and Athletes**

**(Content Meets MDH Requirements)**

Sources: Michigan Department of Community Health. CDC and the National Operating Committee on Standards for Athletic Equipment (NOCSAE)

## UNDERSTANDING CONCUSSION

| | | | |
|---|---|---|---|
| Headache | Pressure in the Head | Nausea/Vomiting | Dizziness |
| Balance Problems | Double Vision | Blurry Vision | Sensitive to Light |
| Sensitivity to Noise | Sluggishness | Haziness | Fogginess |
| Poor Concentration | Memory Problems | Confusion | "Feeling Down" |
| Not "Feeling Right" | Feeling Irritable | Slow Reaction Time | Sleep Problems Grogginess |

## WHAT IS A CONCUSSION?

**A concussion is a type of traumatic brain injury** that changes the way the brain normally works. A concussion is caused by a fall, bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. A concussion can be caused by a shaking, spinning or a sudden stopping and starting of the head. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious. A concussion can happen even if you haven't been knocked out.

You can't see a concussion. Signs and symptoms of concussions can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If the athlete reports any symptoms of a concussion, or if you notice symptoms yourself, seek medical attention right away. An athlete who may have had a concussion should not return to play on the day of the injury and until a health care professional says they are okay to return to play.

## IF YOU SUSPECT A CONCUSSION:

1. **SEEK MEDICAL ATTENTION RIGHT AWAY -** A health care professional will be able to decide how serious the concussion is and when it is safe for the athlete to return to regular activities, including sports. Don't hide it, report it. Ignoring symptoms and trying to "tough it out" often makes it worse.

2. **KEEPING YOUR ATHLETE OUT OF PLAY -** Concussions take time to heal. Don't let the athlete return to play the day of injury and until a health care professional says it's okay. An athlete who returns to play too soon, while the brain is still healing, risks a greater chance of having a second concussion. Young children and teens are more likely to get a concussion and take longer to recover than adults. Repeat or second concussions increase the time it takes to recover and can be very serious. They can cause permanent brain damage, affecting the athlete for lifetime. They can be fatal. It is better to miss one game than the whole season.

3. **TELL THE COACH ABOUT ANY PREVIOUS CONCUSSION** –Coaches should know if an athlete had a previous concussion. An athlete's coach may not know about a concussion received in another sport or activity unless you notify them.

## SIGNS OBSERVED BY PARENTS/LEGAL GUARDIANS:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Can't recall events prior to or after a hit
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood or behavior, or personality changes

## CONCUSSION DANGER SIGNS:

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. An athlete should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awaken
- A headache that gets worse
- Weakness, numbness, or deceased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people/places
- Becomes increasingly confused,
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously.)

## HOW TO RESPOND TO A REPORT OF A CONCUSSION:

If an athlete reports one or more symptoms of a concussion after a bump, blow, or jolt to the head or body, s/he should be kept out of athletic play the day of the injury. The athlete should only return to play with permission from a health care professional experienced in evaluating for concussion. During recovery, rest is key. Exercising or activities that involve a lot of concentration (such as studying, working on the computer, or playing video games) may cause concussion symptoms to reappear or get worse. Athletes who return to sports after a concussion may need to take rests breaks and be given extra help and time. After a concussion, returning to sports is a gradual process that should be monitored by a health care professional. **If a concussion is diagnosed you must have a release form to return to play.**

Remember: Concussion affects people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer
To learn more, go to www.cdc.gov/concussion.

**Parents/Legal Guardians and Athletes (under 18) Must Sign and Return the Application for Participation Form**

Special Olympics Michigan
Central Michigan University, Mt. Pleasant, MI 48859 **Phone:** 800-644-6404 **Fax:** 989-774-3034
**www**.somi.org **Email:** somiforms@somi.org **Facebook** Special Olympics Michigan **Twitter & Instagram** @SpOlympicsMI
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