



LETTER TO BE PROVIDED TO YOUR DOCTOR

Dear Medical Practitioner

Special Olympics Australia is a not-for-profit organisation that provides sports training and competition for people with an intellectual disability across eighteen sports.

Anyone with an intellectual disability is welcome to participate, but they need to register. One of the conditions of registration is that the person must visit a medical practitioner to complete a Health Care Assessment Form. This is to confirm that they are fit and able to participate in sport.

The form was designed by the global Special Olympics medical community to assist medical practitioners to detect conditions that are common among people with an intellectual disability and that may go undetected in a standard physical examination.

We ask that as the medical practitioner you complete the Health Care Assessment Form (page 5), identify if the athlete is fit to participate in sport and sign as required.

Your fees for this consultation can be claimed under the “Health Assessments” category of the Medicare Benefits Schedule. Relevant item numbers are:

- Item 703 Standard (30-45 minutes)
- Item 705 Long (45-60 minutes)
- Item 707 Prolonged (at least 60 minutes)

Thank you for your time. We appreciate your assistance in helping us ensure that the athletes of Special Olympics Australia are fit to play sport.

Yours sincerely

Maureen Scott

New Athlete Registration 2021

Club name

Membership (SOMS) number (Will be provided when you have been registered)

Please return this form along with your registration fee of \$75 to Club Membership Officer

If you have any difficulty with this form, please call Special Olympics Australia on 1300 225 762.

01. Athlete Details

Legal first name

Surname

Preferred name

Date of birth

Male Female

Address

Suburb

State

Postcode

Phone (Home)

Phone (Mobile)

Email

02. Contacts

Main Contact

Relationship to athlete Parent Guardian Carer Sibling Other (Please specify)

First name

Surname

Phone (Home)

Phone (Mobile)

Email

Contact Two

Relationship to athlete Parent Guardian Carer Sibling Other (Please specify)

First name

Surname

Phone (Home)

Phone (Mobile)

Email

Emergency Contact

In the event that the main contact or contact two cannot be reached in case of emergency please supply an alternative emergency contact.

Relationship to athlete Parent Guardian Carer Sibling Other (Please specify)

Name

Phone (Home)

Phone (Mobile)

03. General Information

The following information will help Special Olympics Australia to better understand and support our members. Individual details will not be shared without permission, but any information provided may be used on an anonymous basis to provide an overview of our members.

Does the athlete identify as being of Aboriginal or Torres Strait Islander background? Yes No

Do you identify with an ethnic group? Yes No

If 'Yes' please provide details

Is this athlete a student? Yes No

Institution

Is this athlete employed? Yes No

Employer

Living arrangements Live at home Live independently Live in group home

Are you an NDIS Participant Yes No Prefer not to say

If 'Yes' What type of plan are you on: Self Managed Plan managed Agency Managed Combination Plan

04. Media Consent

I understand that photography and video recording takes place at some Special Olympics Australia sports programs, events and activities, and that I may be incidentally included in such photographs or recordings (images) and that on occasion I may be identifiable from those images. By selecting "Yes" below, I confirm that Special Olympics Australia has my permission to use and/or disclose on its behalf, and allow others to use and/or disclose, any or all such images in television, radio, film, newspapers, magazines, on the internet, and/or in other media, and in any form throughout the world solely for the purpose of publicising, promoting or communicating the purposes and activities of Special Olympics Australia. (Note: Special Olympics Australia will seek separate permissions in relation to individual athlete feature pieces.)

Yes No

05. Payment Details

I wish to pay the registration fee of \$75 by Cash Cheque Money order Direct deposit Credit card

Credit Card

Type of card Visa MasterCard

Card number

Expiry date (MM/YY)

CVV number

Name on card

Cardholder's signature

Please return all forms and payment to Club Membership Officer

Direct Deposit

Account name

Account number

BSB Number

Identifying Persons with Intellectual disabilities

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:

The person has been identified by an agency or professional as having an intellectual disability as determined by their localities;

OR

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

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, behavioural, or emotional disability, or a specific learning or sensory disability, are not eligible to participate as Special Olympics athletes, but may be eligible to participate in other Special Olympics activities please contact your club membership officer for further information

Does the athlete have an intellectual disability as per the above definition? Yes No

OR have 1 of the below conditions

Does the athlete have (tick all that apply)

Autism Down Syndrome Fragile X Syndrome Cerebral Palsy Foetal Alcohol Syndrome

Other (Please specify)

Athlete's Name

Height	Weight	Temperature
Blood Pressure Right	Blood Pressure Left	
Left vision 6 /12 or better <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Left hearing (Finger Rub) <input type="checkbox"/> Responds <input type="checkbox"/> No Response <input type="checkbox"/> Can't Evaluate	
Right vision 6/12 or better <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Right hearing (Finger Rub) <input type="checkbox"/> Responds <input type="checkbox"/> No Response <input type="checkbox"/> Can't Evaluate	
Left Ear Canal <input type="checkbox"/> Clear <input type="checkbox"/> Cerumen <input type="checkbox"/> Foreign Body	Left Tympanic Membrane <input type="checkbox"/> Clear <input type="checkbox"/> Perforation <input type="checkbox"/> Infection	
Right Ear Canal <input type="checkbox"/> Clear <input type="checkbox"/> Cerumen <input type="checkbox"/> Foreign Body	Right Tympanic Membrane <input type="checkbox"/> Clear <input type="checkbox"/> Perforation <input type="checkbox"/> Infection	
Left upper extremity reflex <input type="checkbox"/> Normal <input type="checkbox"/> Diminished <input type="checkbox"/> Hyperreflexia	Right upper extremity reflex <input type="checkbox"/> Normal <input type="checkbox"/> Diminished <input type="checkbox"/> Hyperreflexia	
Left lower extremity reflex <input type="checkbox"/> Normal <input type="checkbox"/> Diminished <input type="checkbox"/> Hyperreflexia	Right lower extremity reflex <input type="checkbox"/> Normal <input type="checkbox"/> Diminished <input type="checkbox"/> Hyperreflexia	
Abdominal Tenderness <input type="checkbox"/> No <input type="checkbox"/> Ruq <input type="checkbox"/> Rlq <input type="checkbox"/> Luq <input type="checkbox"/> Llq		
Kidney Tenderness <input type="checkbox"/> No <input type="checkbox"/> Right <input type="checkbox"/> Left	Oral Hygiene <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	Splenomegaly <input type="checkbox"/> Yes <input type="checkbox"/> No
Bowel Sounds <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatomegaly <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Enlargement <input type="checkbox"/> Yes <input type="checkbox"/> No
Lymph Node Enlargement <input type="checkbox"/> Yes <input type="checkbox"/> No	Lungs <input type="checkbox"/> Clear <input type="checkbox"/> Not clear	Heart Rhythm <input type="checkbox"/> Regular <input type="checkbox"/> Irregular
Heart Murmur (supine) <input type="checkbox"/> No <input type="checkbox"/> 1/6 or 2/6 <input type="checkbox"/> 3/6 or greater	Heart Murmur (upright) <input type="checkbox"/> No <input type="checkbox"/> 1/5 or 2/5 <input type="checkbox"/> 3/5 or greater	
Abnormal Gait <input type="checkbox"/> No <input type="checkbox"/> Yes, describe		
Spasticity <input type="checkbox"/> No <input type="checkbox"/> Yes, describe		
Tremor <input type="checkbox"/> No <input type="checkbox"/> Yes, describe		
Neck & Back Mobility <input type="checkbox"/> Full <input type="checkbox"/> Not full, describe		
Upper Extremity Mobility <input type="checkbox"/> Full <input type="checkbox"/> Not full, describe		
Lower Extremity Mobility <input type="checkbox"/> Full <input type="checkbox"/> Not full, describe		
Lower Extremity Strength <input type="checkbox"/> Full <input type="checkbox"/> Not full, describe		
Upper Extremity Strength <input type="checkbox"/> Full <input type="checkbox"/> Not full, describe		
Radial Pulse Symmetry <input type="checkbox"/> Yes <input type="checkbox"/> R>L <input type="checkbox"/> L>R		
Loss of Sensitivity <input type="checkbox"/> No <input type="checkbox"/> Yes, describe		
Cyanosis <input type="checkbox"/> No <input type="checkbox"/> Yes, describe		
Clubbing <input type="checkbox"/> No <input type="checkbox"/> Yes, describe		
Left Leg Oedema <input type="checkbox"/> No <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+	Right Leg Oedema <input type="checkbox"/> No <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+	

06. Healthcare Assessment Form (continued)

TO BE COMPLETED BY MEDICAL PRACTITIONER

Athlete does not have any neurological symptoms or physical findings that could be associated with spinal cord compression or atlantoaxial instability

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

Please choose **ONE OPTION** to confirm if the athlete is able to participate in Special Olympics sport.

This athlete is fit to participate in Special Olympics Australia sport.

This athlete has medical issues which require further investigation, however the athlete is able to participate in Special Olympics Australia sport.

This athlete wishes to renew their athlete registration but is not fit to participate in Special Olympics Australia sport at this time and must be evaluated by a professional for the following concerns:

OR

A referral has been obtained Yes No

OR

Cardiac Stage II Hypertension or greater
 Neurological Other _____

A referral has been obtained Yes No

Signature of Medical Practitioner

Date

Name

Email

Phone

Provider Number

TO BE COMPLETED BY MEDICAL PRACTITIONER/ATHLETE/PARENT/GUARDIAN/CARER

Has the athlete ever had any of the following conditions?

Dizziness during or after exercise

Yes No

Irregular, racing or skipped heart beats

Yes No

Heart Valve Disease

Yes No

Headache during or after exercise

Yes No

Congenital Heart Defect

Yes No

Heart Murmur

Yes No

Chest pain during or after exercise

Yes No

Heart Attack

Yes No

Vision Impairment

Yes No

Shortness of breath during or after exercise

Yes No

Cardiomyopathy

Yes No

Hearing Impairment

Yes No

Endocarditis

Yes No

Any difficulty controlling bowels or bladder

Yes No

If yes, is this new or worse in the past 3 years? New Worse

Numbness or tingling in legs, arms, hands or feet

Yes No

If yes, is this new or worse in the past 3 years? New Worse

Weakness in legs, arms, hands or feet

Yes No

If yes, is this new or worse in the past 3 years? New Worse

Head Tilt

Yes No

If yes, is this new or worse in the past 3 years? New Worse

Paralysis

Yes No

If yes, is this new or worse in the past 3 years? New Worse

Epilepsy or any type of seizure disorder

Yes No

If yes, is this new or worse in the past 3 years? New Worse

Seizure during the past year

Yes No

If yes, is this new or worse in the past 3 years? New Worse

Spasticity

Yes No

If yes, is this new or worse in the past 3 years? New Worse

Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet

Yes No

If yes, is this new or worse in the past 3 years? New Worse

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

Athlete Signature (only if own guardian)

Date

Legal Guardian Signature (only if not own guardian)

Date

07. Medical Referral

ONLY to be used if the athlete has not been cleared for sports participation

Athlete's Name

Examiners Name

Speciality

I have examined this athlete for the following medical concern(s)

Please describe

In my professional opinion, this athlete may participate in Special Olympics Australia sports (see to the right for restrictions or limitations) Yes No

Additional Practitioners Notes

Medical Practitioner's Signature

Date

Name

Email

Phone

Provider Number

AUTHORISATION

Authorisation for Adult Athlete (Over 18)

Note: Part 1 must be completed by the Adult Athlete. Part 2 must be completed by their parent/guardian/carer or other responsible adult.

Part 01: Athlete

I, _____ (print name), am at least 18 years old and have submitted the attached application for participation in activities and events organised or coordinated by Special Olympics Australia, its volunteers and other organisations under the Special Olympics, Inc. umbrella ("SO Activities").

By signing this form:

- I confirm that to the best of my knowledge and belief, I am physically and mentally able to participate in SO Activities.
- I confirm that there is no medical evidence that would stop me from safely participating in SO activities.
- I confirm that I have read and agree to abide by the enclosed Athlete Code of Conduct.
- I agree that if, during my participation in SO Activities, I need emergency medical treatment, and I am not able to give my consent or make my own arrangements for that treatment for any reason, Special Olympics Australia may take whatever measures it deems necessary to protect my health and well-being, including, if necessary, hospitalisation. (If you have religious objections to receiving such medical treatment, please cross out this paragraph, initial and request a Special Provisions regarding Medical Treatment form).
- I consent to the collection, use and disclosure of my personal information (including sensitive information) as described in the Privacy Statement enclosed. The privacy policy is available on Special Olympics Australia's website (www.specialolympics.com.au/ourwork/privacy).
- I, the athlete named above, have read the provisions of the Authorisation that I am signing. I understand that by signing this paper, I am saying that I agree to the provisions of this Authorisation.

Signature of Adult Athlete

Date

Part 02: Parent/Guardian/Carer/Responsible Adult

By signing this form, I confirm that:

- I am the parent, guardian, carer for, or am otherwise responsible for, the athlete named on this form ("Athlete").
- I am happy for the Athlete to participate in SO Activities.
- I have reviewed this Authorisation and the attached completed registration form with the Athlete.
- I am satisfied based on that review that the information given in the form is accurate and complete and the Athlete understands this Authorisation and has agreed to its terms.
- I consent to the collection, use and disclosure of the personal information (including sensitive information) of the Athlete as described above.
- I understand that my personal information and personal information of any other contacts named in this form ("Contacts") will be collected, used and disclosed to the extent required to facilitate the Athlete's participation in accordance with the privacy policy available on Special Olympics Australia's website (www.specialolympics.com.au/ourwork/privacy), and I have the permission of Contacts to provide their details in this form.

Signature of parent/guardian/carer or other responsible adult

Date

Name (print)

Relationship to athlete

Authorisation for Minor Athlete (Under 18)

Note: to be completed by the parent/guardian of the minor athlete

I am the parent/guardian of _____ (print name), the minor athlete ("Athlete"), on whose behalf I have submitted the attached application for participation in activities and events organised or coordinated by Special Olympics Australia, its volunteers and other organisations under the Special Olympics, Inc. umbrella ("SO Activities").

By signing this form, I confirm that:

- I am the parent/guardian of the Athlete and I give permission for the Athlete to participate in SO Activities.
- I have read and will ensure the Athlete abides by the enclosed athlete's Code of Conduct.
- To the best of my knowledge and belief, the Athlete is physically and mentally able to participate in SO Activities.
- There is no medical evidence that would preclude the Athlete from participating in SO Activities.
- If, during the Athlete's participation in SO Activities, he/she should need emergency medical treatment, and I am not personally present and available to be consulted in advance of that treatment for any reason, I authorise Special Olympics Australia to take whatever measures it deems necessary to protect the Athlete's health and well-being, including, if necessary, hospitalisation. (If the Athlete has religious objections to receiving such medical treatment, please cross out this paragraph, initial and request a Special Provisions regarding Medical Treatment form).
- I have reviewed the attached completed form and I am satisfied based on that review that the information given in the form is accurate and complete.
- I have read this Authorisation and fully understand it. I understand that by signing this Authorisation, I am saying that I agree to the provisions of this Authorisation;
- I consent to the collection, use and disclosure of the personal information (including sensitive information) of the Athlete as described above.
- I understand that my personal information and personal information of any other contacts named in this form ("Contacts") will be collected, used and disclosed to the extent required to facilitate the Athlete's participation in accordance with the privacy policy available on Special Olympics Australia's website (www.specialolympics.com.au/ourwork/privacy/), and I have the permission of Contacts to provide their details in this form.

Signature of parent/guardian

Date

Name (print)