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OFFICIAL SPECIAL OLYMPICS RHODE ISLAND RELEASE FORM

This form must be updated every three years

Local Program:____

Athlete Name: Last:_________________________ First:___________________________ Date of Birth:_______/______/__________
Month Day Year

I represent and warrant that, to the best of my knowledge and belief, I am/my child is/my ward is 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/my child's/my ward's application and has certified, based on an independent medical examination that there is no medical evidence which would preclude me/my child/my ward from participating in Special Olympics. I understand that if I/my child/my ward have Down syndrome, I/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" Form, available from the Special Olympics Program in my state or I/my child/my ward have (has) had a full radiological examination which establishes the absence of Atlanto-axial Instability. I am aware that if I/my child/my ward choose not to complete the "Special Release For Athletes With Atlanto-axial Instability" Form which establishes the absence of Atlanto-axial Instability, I/my child/my ward must have the radiological examination before I/he/she can participate in butterfly stroke, diving starts in swimming, diving, pentathlon, high jump, squat lifts, equestrian sports, artistic gymnastics, football (soccer), alpine skiing, snowboarding and any warm-up activities placing undue stress on the head and neck.

Special Olympics has my permission, (both during and anytime after), to use my/my child's/my ward's likeness, name, voice or words in either television, radio, film, newspapers, magazines, and 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.

TO BE COMPLETED BY
ADULT ATHLETE AND ONE WITNESS

If, during my participation in Special Olympics activities, I should need emergency 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.

My signature on this form grants permission to participate in Healthy Athlete Screenings, including but not limited to vision, dental and hearing screenings. In agreeing to participate, permission is granted to use data collected during the course of any Healthy Athlete Screening for research purposes.

I understand that it is my responsibility to acquire and review the Athlete Code of Conduct form for the safety and health of both myself and my fellow athletes.

I am at least 18 years old and have submitted the application for participation in Special Olympics Rhode Island. 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.

_____________________ _____________________ _______________

SIGNATURE OF WITNESS PRINT NAME OF WITNESS RELATIONSHIP
(e.g. family member, teacher, coach, etc.)

OR

TO BE COMPLETED BY
PARENT OR GUARDIAN OF MINOR ATHLETE

If a medical emergency should arise during the minor athlete's participation in any 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 own behalf and on the behalf of the athlete named above.

I specifically grant permission for the athlete to participate in Healthy Athlete Screenings, including but not limited to vision, dental and hearing screenings. In agreeing to participate, permission is granted to use data collected during the course of any Healthy Athlete Screenings for research purposes.

I hereby give my permission for the athlete named above to participate in Special Olympics games, recreation program, and physical activity programs.

_______________________________________ _______________________

SIGNATURE OF PARENT/GUARDIAN DATE

____

PRINT NAME

*****THIS FORM MUST BE COMPLETED LEGIBLY, SIGNED, AND DATED TO BE CONSIDERED VALID FOR THREE (3) YEARS**