



LUCAS COUNTY SPECIAL OLYMPICS
1154 LARC LANE • TOLEDO, OH 43614
(419) 380-5115 • FAX (419) 380-2636



Dear Interested Athlete:

Thank you for your interest in Lucas County Special Olympics. In order to participate in our program, you must be at least 16 years old, have a qualifying diagnosis and have a current Special Olympics medical form on file with our office.

We have included the medical forms that need filled out. You will need to complete and sign the health history and release form. **Please make sure that the physical examination section is completely filled out by your physician and signed.** Make sure to have them include any restrictions you may have. These forms are valid up to three (3) years from the date of the physician's signature on the form.

Please return completed forms to:
Lucas County Special Olympics
Attn: Lisa Martin

Email: specialolympics@lucasdd.org **Preferred and fastest method
Mail: 1154 Larc Lane, Toledo, OH 43614
or Fax: 419-380-2636

The enclosed Lucas County Special Olympics **Fact Sheet** will give you more details about our program and the sports offered.

Upon receipt of your medical form, your information will be added to our database and you will begin to receive emails each quarter with information of the upcoming sports seasons and how to sign up.

Thanks again for your interest.

Sincerely,

Kelley Watson
Lucas County Special Olympics
Recreation Specialist



Lucas County Special Olympics (LCSO) Adult Program Fact Sheet



Eligibility: In order to participate in LCSO, an individual must reside in Lucas County and be at least 16 years of age. All participants must have a doctor signed Special Olympics medical form on file and documentation that the participant meets one of the following requirements:

1. The person has been identified by an agency or professional as having an intellectual disability; or
2. The person has a cognitive delay as determined by standardized measure; or
3. The person has a closely related developmental disability which means having functional limitations in general learning and adaptive skills.

Sports Currently Offered: Alpine skiing, aquatics (swimming), athletics (track and field), basketball, bocce, competitive cheer, flag football, golf, pep club, power lifting, softball, tennis, and volleyball. In addition, we offer the following unified sports, where individuals with and without disabilities participate together: corn hole, flag football, golf, and softball.

Information Sharing: You will receive 3-4 mailings each year about sports offered by LCSO, news about LCSO athletes and coaches, and updates on fundraising. Please follow instructions in the mailings to register for sport training programs. Mailings are sent to athletes who have a current medical form on file with our office. So that more athletes can participate, we ask that you train in only one sport per season.

Fund Raising: According to Special Olympic rules, training and competition is free to LCSO athletes. Each year we have expenses related to umpires/referees, facility fees, competition/entry fees, equipment, uniforms, charter bus rental, and meals / lodging when we attend out of town competition, such as Summer Games. These costs must be covered by donations and fundraising. LCSO expects that all who participate will take part in our fundraising efforts. If funds are not available, the number of athletes attending or participation in an event may be affected. If you or your family member would like to be a part of our fundraising committee, please contact our office.

Code of Conduct: All athletes, volunteers, spectators, and coaches must abide by the Special Olympic Code of Conduct. This Code of Conduct is discussed at the beginning of each training season and athletes and/or their guardian sign a form indicating they have received and understand it. Violations of the code of conduct may result in suspension from competitions and/or the program. Smoking and the use of alcohol are not allowed while in uniform or at any Special Olympic program or event.

Personal Safety: Please be advised that some of the individuals who participate in LCSO have personal space issues. We ask that all athletes and volunteers treat each other respectfully and limit physical contact to handshakes and high fives.

Supervision: It is not the role of LCSO staff to provide supervision to anyone at any practice, competition or overnight stays. As a result, if an athlete requires supervision for any safety, medical, dietary and/or behavioral concerns, they must be accompanied by an adult family member or a homemaker/personal care staff that is familiar with their needs. Please note that LCSO staff, volunteers, and coaches have not been trained on athletes' Person Centered and Specialized Support Plans so we are unaware of potential concerns. LCSO athletes attending competitions involving an overnight stay generally share rooms with other athletes. Chaperones are housed in nearby rooms.

Have any questions? Please contact:
Kelley Watson, LCSO Recreation Specialist-Local SO Coordinator
(419) 380-5109 or kwatson@lucasdd.org

Lucas County Special Olympics
1154 Larc Lane
Toledo, OH 43614
(419) 419-380-5115

ANNOUNCING

**Special Olympics' physicals are now available
for a fee of \$35.00!!**

**We are able to offer this through a
partnership with**

ProMedica Physicians Sports Medicine

and

Lucas County Special Olympics

Location and Phone number:

2865 N. Reynolds, Toledo, Suite 170

To schedule your appointment call: 419-578-7590.

***** You will need to take a Special Olympics Ohio physical form with you to the appointment. Please have the form completed as much as possible before your appointment. The most current forms can be found at lucasdd.org/special-olympics/registration or call 419/380-5110 to request them be sent to you.***



ATHLETE REGISTRATION FORM

Special Olympics



State Special Olympics Program: Ohio 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):		<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other Gender Identity
Race/Ethnicity: <input type="checkbox"/> Prefer not to answer		
<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Asian American	<input type="checkbox"/> More than one race
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	
<input type="checkbox"/> White or Caucasian	<input type="checkbox"/> Hispanic or Latinx	
Language(s) Spoken in Athlete's Home (Optional): Check all that apply		
<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
PARENT / GUARDIAN INFORMATION (required if minor or otherwise has a legal guardian)		
Name:		
Relationship:		
<input type="checkbox"/> Same Contact Info as Athlete		
Street Address:		
City:	State:	Zip Code:
Phone:	E-mail:	
EMERGENCY CONTACT INFORMATION		
<input type="checkbox"/> Same as Parent/Guardian		
Name:		
Phone:	Relationship:	
PHYSICIAN & INSURANCE INFORMATION		
Physician Name:		
Physician Phone:		
Insurance Company:	Insurance Policy Number:	
Insurance Group Number:		

Athlete Medical Form – HEALTH HISTORY

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



Athlete First & Last Name: _____

Preferred Name: _____

Athlete Date of Birth (mm/dd/yyyy): _____

Female Male Other Gender Identity

STATE PROGRAM: Ohio

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
 Aggressive behavior during the past year No Yes
 Depression (diagnosed) 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	<input type="checkbox"/> No <input type="checkbox"/> Yes	High Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	Stroke/TIA	<input type="checkbox"/> No <input type="checkbox"/> Yes
Dizziness during or after exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes	High Cholesterol	<input type="checkbox"/> No <input type="checkbox"/> Yes	Concussions	<input type="checkbox"/> No <input type="checkbox"/> Yes
Headache during or after exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes	Vision Impairment	<input type="checkbox"/> No <input type="checkbox"/> Yes	Asthma	<input type="checkbox"/> No <input type="checkbox"/> Yes
Chest pain during or after exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hearing Impairment	<input type="checkbox"/> No <input type="checkbox"/> Yes	Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Shortness of breath during or after exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes	Enlarged Spleen	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hepatitis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Irregular, racing or skipped heart beats	<input type="checkbox"/> No <input type="checkbox"/> Yes	Single Kidney	<input type="checkbox"/> No <input type="checkbox"/> Yes	Urinary Discomfort	<input type="checkbox"/> No <input type="checkbox"/> Yes
Congenital Heart Defect	<input type="checkbox"/> No <input type="checkbox"/> Yes	Osteoporosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Spina Bifida	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Attack	<input type="checkbox"/> No <input type="checkbox"/> Yes	Osteopenia	<input type="checkbox"/> No <input type="checkbox"/> Yes	Arthritis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Cardiomyopathy	<input type="checkbox"/> No <input type="checkbox"/> Yes	Sickle Cell Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Heat Illness	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Valve Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Sickle Cell Trait	<input type="checkbox"/> No <input type="checkbox"/> Yes	Broken Bones	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Murmur	<input type="checkbox"/> No <input type="checkbox"/> Yes	Easy Bleeding	<input type="checkbox"/> No <input type="checkbox"/> Yes	Dislocated Joints	<input type="checkbox"/> No <input type="checkbox"/> Yes
Endocarditis	<input type="checkbox"/> No <input type="checkbox"/> 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	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Numbness or tingling in legs, arms, hands or feet	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Weakness in legs, arms, hands or feet	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Head Tilt	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Spasticity	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Paralysis	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, is this new or worse in the past 3 years?	<input type="checkbox"/> No <input type="checkbox"/> 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: _____ Date of Birth _____

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 <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A		
in	lbs	Body Fat %	F					Left Vision 20/40 or better <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A		

Right Hearing (Finger Rub) <input type="checkbox"/> Responds <input type="checkbox"/> No Response <input type="checkbox"/> Can't Evaluate <input type="checkbox"/>	Bowel Sounds <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
Left Hearing (Finger Rub) <input type="checkbox"/> Responds <input type="checkbox"/> No Response <input type="checkbox"/> Can't Evaluate <input type="checkbox"/>	Hepatomegaly <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>
Right Ear Canal <input type="checkbox"/> Clear <input type="checkbox"/> Cerumen <input type="checkbox"/> Foreign Body <input type="checkbox"/>	Splenomegaly <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>
Left Ear Canal <input type="checkbox"/> Clear <input type="checkbox"/> Cerumen <input type="checkbox"/> Foreign Body <input type="checkbox"/>	Abdominal Tenderness <input type="checkbox"/> No <input type="checkbox"/> RUQ <input type="checkbox"/> RLQ <input type="checkbox"/> LUQ <input type="checkbox"/> LLQ
Right Tympanic Membrane <input type="checkbox"/> Clear <input type="checkbox"/> Perforation <input type="checkbox"/> Infection <input type="checkbox"/> NA <input type="checkbox"/>	Kidney Tenderness <input type="checkbox"/> No <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/>
Left Tympanic Membrane <input type="checkbox"/> Clear <input type="checkbox"/> Perforation <input type="checkbox"/> Infection <input type="checkbox"/> NA <input type="checkbox"/>	Right upper extremity reflex <input type="checkbox"/> Normal <input type="checkbox"/> Diminished <input type="checkbox"/> Hyperreflexia <input type="checkbox"/>
Oral Hygiene <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/>	Left upper extremity reflex <input type="checkbox"/> Normal <input type="checkbox"/> Diminished <input type="checkbox"/> Hyperreflexia <input type="checkbox"/>
Thyroid Enlargement <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>	Right lower extremity reflex <input type="checkbox"/> Normal <input type="checkbox"/> Diminished <input type="checkbox"/> Hyperreflexia <input type="checkbox"/>
Lymph Node Enlargement <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>	Left lower extremity reflex <input type="checkbox"/> Normal <input type="checkbox"/> Diminished <input type="checkbox"/> Hyperreflexia <input type="checkbox"/>
Heart Murmur (supine) <input type="checkbox"/> No <input type="checkbox"/> 1/6 or 2/6 <input type="checkbox"/> 3/6 or greater <input type="checkbox"/>	Abnormal Gait <input type="checkbox"/> No <input type="checkbox"/> Yes, describe below
Heart Murmur (upright) <input type="checkbox"/> No <input type="checkbox"/> 1/6 or 2/6 <input type="checkbox"/> 3/6 or greater <input type="checkbox"/>	Spasticity <input type="checkbox"/> No <input type="checkbox"/> Yes, describe below
Heart Rhythm <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/>	Tremor <input type="checkbox"/> No <input type="checkbox"/> Yes, describe below
Lungs <input type="checkbox"/> Clear <input type="checkbox"/> Not clear <input type="checkbox"/>	Neck & Back Mobility <input type="checkbox"/> Full <input type="checkbox"/> Not full, describe below
Right Leg Edema <input type="checkbox"/> No <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+ <input type="checkbox"/>	Upper Extremity Mobility <input type="checkbox"/> Full <input type="checkbox"/> Not full, describe below
Left Leg Edema <input type="checkbox"/> No <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+ <input type="checkbox"/>	Lower Extremity Mobility <input type="checkbox"/> Full <input type="checkbox"/> Not full, describe below
Radial Pulse Symmetry <input type="checkbox"/> Yes <input type="checkbox"/> R>L <input type="checkbox"/> L>R <input type="checkbox"/>	Upper Extremity Strength <input type="checkbox"/> Full <input type="checkbox"/> Not full, describe below
Cyanosis <input type="checkbox"/> No <input type="checkbox"/> Yes, describe <input type="checkbox"/>	Lower Extremity Strength <input type="checkbox"/> Full <input type="checkbox"/> Not full, describe below
Clubbing <input type="checkbox"/> No <input type="checkbox"/> Yes, describe <input type="checkbox"/>	Loss of Sensitivity <input type="checkbox"/> No <input type="checkbox"/> 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:
- | | | |
|--|---|--|
| <input type="checkbox"/> Concerning Cardiac Exam | <input type="checkbox"/> Acute Infection | <input type="checkbox"/> O ₂ Saturation Less than 90% on Room Air |
| <input type="checkbox"/> Concerning Neurological Exam | <input type="checkbox"/> Stage II Hypertension or Greater | <input type="checkbox"/> Hepatomegaly or Splenomegaly |
| <input type="checkbox"/> Other, please describe: _____ | | |

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

- | | | |
|---|--|---|
| <input type="checkbox"/> Follow up with a cardiologist | <input type="checkbox"/> Follow up with a neurologist | <input type="checkbox"/> Follow up with a primary care physician |
| <input type="checkbox"/> Follow up with a vision specialist | <input type="checkbox"/> Follow up with a hearing specialist | <input type="checkbox"/> Follow up with a dentist or dental hygienist |
| <input type="checkbox"/> Follow up with a podiatrist | <input type="checkbox"/> Follow up with a physical therapist | <input type="checkbox"/> Follow up with a nutritionist |
| <input type="checkbox"/> Other/Exam Notes: _____ | | |

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

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 O₂ 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

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:



LUCAS COUNTY SPECIAL OLYMPICS
 1154 LARC LANE • TOLEDO, OH 43614
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TeamReach App Acknowledgment From

Lucas County Special Olympics uses a free app for mobile devices to allow us to communicate to our various teams throughout the season. We utilize this for the following reasons:

1. TeamReach provides us with one place for all communication about the team you are on which stops the need for phone calls, emails, and handouts.
2. We are able to send messages, post team schedules, provide event details, such as location/addresses and post pictures.
3. Anyone that has joined the group on the app can set it up so notifications such as messages and changes in schedules show up on your phone. This is great for notifications of any schedule changes, including any last-minute cancellations.
4. It's a safe way for staff, coaches, athletes, providers and parents to communicate without exchanging contact information.

To use the TeamReach app, you must download it from your app store on your mobile device. It is free, so there is no cost to do so. Because it is free, there will be ads that pop up while in the app. There is no way to avoid this unless you pay for the app. So, we ask that you simply ignore them. We in no way support or approve the ads that are in the app.

You will receive instructions and password to sign up for the team you are assigned to. Each team will have a separate group on the app. Please note that this is changed every season/sport.

I agree and consent to using TeamReach for Lucas County Special Olympics sports teams. By signing this form, I acknowledge that I have willingly downloaded the app, understand that everyone that has joined the group/team on the app could contact me through the app, but understand my contact information will not be accessible to anyone.

Print Name of Athlete/Guardian

Signature

Date

This form is valid and will expire when the athlete's Special Olympics physical form expires, once every 3 years. The athlete has the right to revoke this at any time. To do so, please notify a Lucas County Special Olympics staff person in writing.