ATHLETE REGISTRATION

Special Olympics

Dear Special Olympics Athletes, Parents, and Guardians:

Through the power of sports, our athletes find joy, confidence and fulfillment — on the playing field and in life. Whether you are new to Special Olympics or have been involved for years, we are excited you are part of the movement!

To register or re-register as a Special Olympics athlete, please complete the enclosed forms:

☐ **REGISTRATION FORM.** This form asks for contact and other information.

☐ **RELEASE FORM.** This form goes over some important details about Special Olympics participation.

☐ **MEDICAL FORM.** This form is designed to identify health concerns that are more common among people with intellectual disabilities and clear an athlete to participate. Please fill out the Health History section on pages 1 and 2. If you do not understand any parts of the form, you may leave those parts blank to be discussed during the exam. The Physical Exam section on page 3 should be filled out and signed by a licensed medical professional (for example, Physician, Registered Nurse Practitioner, or Physician Assistant). If an athlete requires further examination due to a concerning health issue before clearance can be determined, a referral form is available on the fourth page.

The Release Form and the Medical Form instruct you to complete other forms in certain uncommon situations. If this applies to you or if you have any other questions, please contact Special Olympics New York at 631-254-1465 x 4120.

Please submit registration forms to the Long Island Office:

560 Broadhollow Rd, Suite 106

Melville, NY 11747

Fax: 631-812-5558

Email: jlodispoto@nyso.org

One copy should be given to each coach. A parent/guardian should also retain a copy of these forms for their own records.

ATHLETE REGISTRATION FORM

Special Olympics

State Special Olympics Program: New York (Training Club Name) **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	
Race/Ethnicity (Optional): ☐ American Indian/Alaskan Native ☐ Asian ☐ Two or More Races ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Hispanic or Latino (specific origin group:_____)		
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:		

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_2Sat	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

COVID-19 Participant Code of Conduct and Risk Assessment Form

Special Olympics

I understand I could get Coronavirus through sports, training, competition and/or any group activity at Special Olympics. I am choosing to participate in sports, competition and/or other Special Olympics activities at my own risk.

During the time these precautions are needed, I agree to the following to help keep me and my fellow participants safe:

☐	If I have COVID-19 symptoms, I will stay at home and NOT go to any activities until 7 days after all of my symptoms are over. If I am exposed to COVID-19 and have no symptoms, I must self-quarantine if required by local regulations
☐	Special Olympics gave me education on Special Olympics rules for COVID-19 and who is at high-risk.
☐	I know that if I have a high-risk condition, I have more risk that I could get sick or die from COVID-19. If I have a high-risk condition and am not fully vaccinated, I should not go to Special Olympics events in person, until there is little or no Coronavirus in my community.
☐	I know that before or when I get to a Special Olympics activity, they may ask me some questions about symptoms and exposure to COVID-19. They may also take my temperature. I will answer truthfully and participate fully.
☐	I will keep at least 6 ft/2m from all participants at all times, when asked
☐	I will wear a mask at all times while at Special Olympics activities when asked. I may not have to wear it during active exercise.
☐	I will wash my hands for 20 seconds or use hand sanitizer before any activities. I will wash my hands any time I sneeze, cough, go to the bathroom or get my hands dirty.
☐	I will avoid touching my face. I will cover my mouth when I cough or sneeze and immediately wash my hands after.
☐	I will not share drinking bottles or towels with other people.
☐	I will only share equipment when instructed to. If equipment must be shared, I will only touch the equipment if it is disinfected first.
☐	If I get or have had COVID, I will not go to any in-person Special Olympics events until 7 days after my symptoms end. I will go to my doctor and get written clearance before returning to any sport or fitness activities.
☐	I understand that if I do not follow all of these rules, I may not be allowed to participate in Special Olympics activities during this time.

Updated June 2021

COVID-19 Participant Code of Conduct and Risk Assessment Form

Special Olympics

I HAVE READ ALL OF THIS AGREEMENT OR HAVE HAD IT READ TO ME AND AGREE TO FOLLOW THESE ACTIONS.

PARTICIPANT FULL NAME: _____

Phone: _____ **Email:** _____

Circle one: Athlete Unified Partner Coach/Volunteer Family/Caregiver Staff

PARTICIPANT SIGNATURE *(required for adult (age 18+) participants, including adult athlete with capacity to sign documents)*

By signing this, I acknowledge that I have completely read and fully understand the information in this form.

Signature: _____ **Date:** _____

PARENT/GUARDIAN SIGNATURE *(required for participant who is a minor (younger than age 18) or lacks capacity to sign documents)*

I am a parent or guardian of the athlete/participant named above. I have read and understand this form and have explained the contents to the participant as appropriate. By signing, I agree to this form on my own behalf and on behalf of the participant.

Parent/Guardian Signature: _____ **Date:** _____

Printed Name: _____

Relationship: _____

Fact Sheet on Who is at Higher Risk from COVID-19

Special Olympics

Subject to Change
Version: 6-28-2021

Who is at higher risk of COVID-19?

COVID-19 is a relatively new disease and information is changing on who is more likely to get COVID-19 and who is will have more complications.

Current clinical guidance and information from the U.S. Centers for Disease Control and Prevention (CDC) and World Health Organization (WHO) lists those at high-risk for severe illness from COVID-19 as:

- Unvaccinated people 60 years and older. Risk increases with age.
- Unvaccinated people with disabilities (resulting from long-standing systemic health and social inequities)

Regardless of age, individuals who are **unvaccinated** and have underlying conditions, such as the following, are or maybe at increased risk of severe illness from COVID-19:

- People with chronic lung disease, chronic obstructive pulmonary disease or moderate to severe asthma, interstitial lung disease, cystic fibrosis, and pulmonary hypertension
- People who have serious heart conditions (including heart failure, coronary artery disease, congenital heart disease, cardiomyopathy, hypertension)
- People who have HIV and/or are immunocompromised
- People with obesity or who are overweight (body mass index [BMI] of 25 or higher). To calculate BMI, refer to:
    - https://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/english_bmi_calculator/bmi_calculator.html
- People with cancer
- People with diabetes (Type 1 and 2)
- People with chronic kidney disease
- People with liver disease
- People with dementia
- People with down syndrome
- People who are pregnant
- People who are smokers, current or former
- People with a substance abuse disorder
- People with sickle cell disease or thalassemia
- People who have had a stroke or cerebrovascular disease

The list may change as evidence is learned. Please review the latest list of conditions that put individuals at increased risk available at the CDC website (https://bit.ly/2VEJcSK)

If you are at a high risk and unvaccinated, you may be putting yourself at risk when you return to activities with Special Olympics. But, you may also put your family and your teammates at risk. If you have these conditions, it is strongly recommended that you should not return to Special Olympics in person activities until you are vaccinated or the community transmission in your community is low.

If you have been diagnosed with COVID-19, you should consult with a healthcare professional for written medical clearance before returning to Special Olympics in person activities as serious cardiac, respiratory, and neurological issues may develop as a result of COVID-19.

Updated June 2021

WAIVER AND RELEASE OF LIABILITY, ASSUMPTION OF RISK AND INDEMNIFICATION AGREEMENT FOR COMMUNICABLE DISEASES
("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:

1. 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,

2. 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,

3. 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,

4. 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 New York, 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 IF 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)

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: _____