

YOUNG ATHLETES APPLICATION

Please print clearly and complete all sections in their entirety. Children are eligible for Young Athletes™ provided they are age 2-7. Both children with and without an intellectual disability are encouraged to be part of the Young Athletes™ program.

SECTION A: DEMOGRAPHICS

Athlete Name: _____ Male Female
Athlete Address: _____ Date of Birth (month/date/year): ____ / ____ / ____
City: _____ State: _____ Zip: _____ Parent Home Phone: (____) _____
Parent/Guardian Name: _____ Parent Work Phone: (____) _____
Emergency Contact (other than Parent/Guardian): _____ Parent Email: _____
Young Athlete is being registered as a: Emergency Contact Phone: (____) _____
A. Traditional Young Athlete (diagnosed with intellectual disability) Yes No
What is the diagnosis? _____ Does the child attend a formal daycare or preschool program?
B. Peer Partner (doesn't have a diagnosed intellectual disability) Does the child attend school? _____
(What grade/year: _____)
T-shirt size (2t-youth large): _____

SECTION B: YOUNG ATHLETE PROGRAM LOCATION

What is the location of the Young Athletes program? _____

SECTION C: HEALTH HISTORY

FOR SITE USE ONLY

please indicate "yes" or "no" for all areas

Yes	No		Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	Allergies:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Blindness/Visual Problems (other than corrective lenses)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Bone or Joint Problem	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Concussion or Serious Head Injury	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Contact Lenses/Glasses	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Emotional/Psychiatric/Behavioral Problems	<input type="checkbox"/>	<input type="checkbox"/>
		If yes, what behavior management strategies are used at home? _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Special dietary concerns: _____	<input type="checkbox"/>	<input type="checkbox"/>

additional notes: _____

SIGNATURE OF PARENT/GUARDIAN (REQUIRED): _____ DATE: ____ / ____ / ____

(By signing this application you acknowledge the waiver on the back.)

Signature Required

SECTION D: CONSENT TO BE COMPLETED BY PARENT/GUARDIAN

I am the parent/guardian of _____, I completed the Application for Participation in Young Athletes™ for child. I give my permission for child to participate in Special Olympics Young Athletes™ activities.

I further represent and warrant that to the best of my knowledge and belief, the child is physically and mentally able to participate in Special Olympics activities. **(Do you have more than one child participating? See below.)**

I grant my permission, (both during and anytime after), to Special Olympics to use child's likeness, name, voice and words in 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 those purposes and activities.

If a medical emergency should arise during the child's participation in any Special Olympics activities, at a time when I am not personally present so as to be personally consulted regarding the child's care, I give Special Olympics permission, to do whatever is necessary to get child the care and any emergency medical treatment they need. I understand Special Olympics will make the decision to do what is best to protect the child's health and well-being.

I am the parent/guardian of the child named in this application. I have read and understand this document. I signed this consent form to show I agree to the conditions of the document for me and for my child.

I give my permission for child to participate in Special Olympics Young Athletes games, recreation programs and physical activity programs.

I give my permission to _____ to give Special Olympics Minnesota my child(ren)'s; name, **Program Location Name** gender, date of birth and athlete status (athlete: is a child diagnosed with an intellectual disability. Peer partner: is a child that is not diagnosed with an intellectual disability).

* Child is defined as the person who will be participating in Special Olympics Young Athletes™

Please print your name: _____

I would like to receive more information about Special Olympics programs.

Address: _____
Street City State Zip

Phone: (____) _____

Email address: _____

CHILDREN PARTICIPATING:

1. _____
2. _____
3. _____
4. _____
5. _____