TEMPORARY ATHLETE REGISTRATION FORM

Special Olympics Ireland is a sports organisation for children and adults with an intellectual disability.
Special Olympics Ireland is committed to protecting your privacy. This form will be processed in accordance with the General Data Protection Regulation (GDPR) and the Data Protection Acts 1988-2018.

Your data is solely used for the purpose of administering Special Olympics programmes.

Please complete ALL sections in BLOCK CAPITALS using Black or Blue ink.

Non-disclosure or failure to update information on the athelte's physical or mental health, their behaviour or medication, at any time, may invalidate the athlete's registration with the affilitated club.

Section 1 Athlete Information

First Name
Middle Name
Surname
Preferred First Name
Date of Birth (DD/MM/YYYY) / /
Gender: Male Female Other
Address:
Eircode:

Phone Number
Landline:
Mobile:

Parent

First Name:
Surname:
Relationship to athlete:
Phone:
Email:

Guardian/ Next of Kin

First Name:
Surname:
Relationship to athlete:
Phone:
Email:

Affiliate Club Name

Please provide the name of the affiliate Club(s) where the athlete is an athlete member or is applying for membership and state sport(s) involved.

Club:
Sport/s:

Club:
Sport/s:

Section 2 Photography consent

From time to time Special Olympics Ireland and/or the affiliated club, may undertake marketing and communications activities in order to promote the organisation for the purposes of, but not limited to, fundraising, awareness and sponsorship.
The below section is relating to your consent in the use of photography of the athlete member.

Consent is sought for the use of my photo or image,which may be taken whilst attending or participating in Games, competition or activities connected with the club and/or Special Olympics Ireland, and consent to it being used by the club and/or Special Olympics Ireland for the purposes listed above.

☐ I do give my consent relating to the above statement ☐ I do not give my consent relating to the above statement

Signature _____

☐ I understand that I can withdraw my consent at any time by writing to the club or Special Olympics Ireland.

Declaration and Release

Special Olympics requests that prior to signing the health release you confirm with the General Practitioner (GP) of the athlete to ensure that there is no health/medical reason to preclude the individual's participation in the activities that they are registering to participate in.

I represent and warrant that to the best of my knowledge and belief that _____is physically able to participate in the Special Olympics Ireland programme and that there is no medical evidence which would preclude or render inadvisable the athletes participation.

By signing below, permission is granted for this athlete to participate in the Special Olympics Healthy Athlete programme that provides individual screening assessments of health status and health care needs in the areas of vision, oral health, hearing, physical therapy and a variety of health promotion areas (height, weight, sun protection etc.) It is understood these assessments are not intended for diagnosis or treatment and that provision of these health services is not intended as a substitute or alternative to regular care that has been received in the past or that may be recommended in the future.

It is also understood that this athlete should seek his/her own medical advice and assistance irrespective of the provision of these services and that Special Olympics Ireland, through the provision of these services, is not making itself responsible for the athlete's health. It is understood that information gathered as part of the screening process may be used in group form (anonymously) to assess and communicate the overall health needs and to develop programs to address those needs.

If a medical emergency should arise during the athlete's participation in Special Olympics Ireland activities at a time when the athlete is not able to give his/her consent or make his/her own arrangements for treatment because of his/her injuries or when the parent/guardian of the athlete (in the case where the applicant is under the age of 18) is not personally present so as to be consulted regarding the athlete's care, Special Olympics Ireland is authorised to take whatever measures it shall deem necessary to ensure that the athlete is provided with any emergency medical treatment necessary, including hospitalisation, in order to protect the athlete's health and well-being.

Declaration And Release Form Continued On Next Page

Please proceed and complete as follows:

Section 2(a) If the athlete is an ADULT ATHLETE (over 18 years of age)

Part (i) Where an athlete is signing the form on their own behalf

OR

Part (ii) Where a parent/guardian or next of kin signs the form on behalf of the athlete

OR

Section 2(b) If the athlete is a MINOR ATHLETE (under 18 years of age)

Section 2(a) To be completed if the athlete is an ADULT ATHLETE (over 18yrs of age)

Only need to complete PART (i) **OR** PART (ii)

PART (i) Adult Athlete is signing the form on their own behalf

I DECLARE that, to the best of my knowledge and belief, all the particulars given in this form are correctly stated.

I 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.

Print Name:

Signature:

Date: / /

DD MM YYYY

WITNESS SIGNATURE

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 (participant with an intellectual disability) understands this release and has agreed to its terms.

Print Name:

Signature:

Date: / /

DD MM YYYY

State your relationship to the athlete:

Parent

Guardian

Next of Kin

Other

If "other" state your relationship

PART (ii) Parent/Guardian/Next of Kin is signing the form on behalf of the athlete

I am the Parent /Guardian /Next of Kin of

the above mentioned athlete with an intellectual disability who wishes to participate in the Special Olympics Ireland programme.

I represent and warrant that to the best of my knowledge the athlete is physically and mentally able to participate in the Special Olympics Ireland programme and, in particular, the activities for which he/she has applied to particpate in, and has taken appropriate medical advice in relation to his/her participation in the Special Olympics Ireland programme.
I confirm that the athlete is able to and does understand the provisions of the above release. Through my signature I am agreeing to the above provisions on my own behalf and on behalf of the athlete and I DECLARE that,to the best of my knowledge and belief, all the particulars given are correctly stated.

Print Name:

Signature:

Date: / /

DD MM YYYY

State your relationship to the athlete:

Parent

Guardian

Next of Kin

Other

If "other" state your relationship

Section 2(b) To be completed if the athlete is a MINOR ATHLETE (an individual under the age of 18)

I am the parent/guardian/next of kin of , (the 'athlete') a minor on whose behalf I have submitted the attached application for participation in the Special Olympics Ireland Programme . I hereby represent and warrant that the athlete has my permission to participate in the Special Olympics Ireland Programme.

I represent and warrant that to the best of my knowledge the athlete is physically and mentally able to participate in the Special Olympics Ireland programme and in particular the activities for which he/she has applied to participate in, and has taken appropriate medical advice in relation to his/her participation in the Special Olympics programme.

I DECLARE that, to the best of my knowledge and belief, all the particulars given in this form are correctly stated.
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.

Print Name:

Signature:

Date: / /

DD MM YYYY

State your relationship to the athlete:

Parent Guardian Next of Kin Other

Section 3 Athlete Health Record (to be completed by guardian or family)

If athlete has a history of any of the following or requires additional support please tick Yes and refer as directed to the subsequent section to provide further details otherwise tick No

Epilepsy or any type of seizure disorder YES ☐ NO ☐

If yes list seizure type

Number of seizures in the past year ☐

Date of last seizure (if known) ☐☐ / ☐☐ / ☐☐☐☐
DD MM YYYY

Heart

If yes please indicate if you have a history of any of the following:

	YES	NO
Heart attack	☐	☐
Heart murmur	☐	☐
High blood pressure	☐	☐
Heart Surgery	☐	☐
Shortness of breath/dizziness/ headache on exercise	☐	☐
High cholesterol	☐	☐
Family history of heart disease	☐	☐

Diabetes

YES ☐ NO ☐

If yes please indicate if you have a history of any of the following:

	YES	NO
Insulin Dependant	☐	☐
Managed by diet alone	☐	☐
History of Hypoglycaemia	☐	☐
History of Hyperglycaemia or Diabetic Ketoacidosis	☐	☐

Asthma

YES ☐ NO ☐

If yes please indicate if you have a history of the following:

	YES	NO
Status Asthmaticus	☐	☐

Mobility

YES ☐ NO ☐

If yes please indicate if you have a history of any of the following:

	YES	NO
Fully mobile	☐	☐
Wheelchair user	☐	☐
part time	☐	
full time	☐	
Assistance needed	☐	☐

Outline the assistance required

Hearing

Please indicate below

	YES	NO
Hearing difficulty	☐	☐
Hearing Aid	☐	☐

Communication

How does athlete normally communicate?

Outline any support devices/ communication tools used

Sensory Issues

YES ☐ NO ☐

Please list types

Vision

	YES	NO
Right eye vision normal	☐	☐
Left Eye vision normal	☐	☐
Wears glasses or lens	☐	☐

Please indicate if you have a history of any of the following:

	YES	NO
Glaucoma	☐	☐
Other	☐	☐

Outline any assistive devices/ aids used

Dietary requirements

YES ☐ NO ☐

If yes, please identify below:

	YES	NO
Coeliac	☐	☐
Diabetic	☐	☐
Vegetarian	☐	☐
No Pork	☐	☐

Other dietary restriction please indicate

Allergies

YES ☐ NO ☐

If yes, please indicate if you have a history of allegeries to any of the following:

	YES	NO
Latex,	☐	☐
Medication	☐	☐
Insects bites or stings	☐	☐
Food	☐	☐

Other please state name of medication

Behavioural and Mental Health

Please indicate if you have a history of any of the following:

	YES	NO
Self-Injurious behaviour in the past	☐	☐
Aggressive behaviour	☐	☐
Verbal outbursts	☐	☐
Runs away /absconds	☐	☐
Withdrawn	☐	☐
Sexually inappropriate behaviour	☐	☐
Other behaviour	☐	☐
Depression diagnosed	☐	☐
Anxiety diagnosed	☐	☐
Other mental health issues	☐	☐

If the athlete needs support to manage their behaviour please provide information to support your athlete at the time the behavious occurs so that the information can assist the volunteer to manage the situation.

What might trigger the athlete to display the behaviour?

If upset or agitated how is this managed?

Outline the behavioural support strategies used

List any support aids/devices used

Section 3 Athlete Health Record continued (to be completed by guardian or family member)

Does the athlete have any religious objections to medical treatment? Yes ☐ No ☐

If yes, please specify:

Is the athlete taking any medication? Yes ☐ No ☐

If yes, please specifiy prescribed medication below, otherwise skip to Section 6.

Is the athlete self medicating? Yes ☐ No ☐

(a) Prescribed medication

Medication name:
Dosage amount:
Frequency of dosage:

(b) Prescribed medication

Medication name:
Dosage amount:
Frequency of dosage:

(c) Prescribed medication

Medication name:
Dosage amount:
Frequency of dosage:

(d) Prescribed medication

Medication name:
Dosage amount:
Frequency of dosage:

(e) Prescribed medication

Medication name:
Dosage amount:
Frequency of dosage:

(f) Prescribed medication

Medication name:
Dosage amount:
Frequency of dosage:

(g) Prescribed medication

Medication name:
Dosage amount:
Frequency of dosage:

(h) Prescribed medication

Medication name:
Dosage amount:
Frequency of dosage:

(i) Prescribed medication

Medication name:
Dosage amount:
Frequency of dosage:

(j) Prescribed medication

Medication name:
Dosage amount:
Frequency of dosage:

(k) Prescribed medication

Medication name:
Dosage amount:
Frequency of dosage:

(l) Prescribed medication

Medication name:
Dosage amount:
Frequency of dosage:

Signature: Athlete's Parent/Guardian/Next of Kin:

Date:

If more space is required for additional medications please photocopy this page of the form.