



# TEMPORARY ATHLETE REGISTRATION FORM

Special Olympics Ireland is a sports organisation for people with an intellectual disability. We are 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 and in accordance with the Data Protection Act 2018 (UK) for Northern Ireland  
Your data is solely used for the purpose of administering Special Olympics Programmes.  
Non-disclosure or failure to update information on the athlete's physical or mental health, their behaviour or medication, at any time, may invalidate the athlete's registration with the affiliated club.

## Section 1 Athlete Information Please complete ALL sections in BLOCK CAPITALS using Black or Blue ink.

First Name:

Middle Name:

Surname:

Preferred First Name:

Date of Birth (DD/MM/YYYY)  /  /

Gender:  Male  Female  Other

Address:

Eircode/Postcode:

Phone Number  
Landline:

Mobile:

For office use only, please insert Athlete ID.  
Athlete ID:

Please tick the relevant box to indicate your relationship to the athlete.

### 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 applying for membership and state sport(s) involved.

Club:

Sport/s:

Club:

Sport/s:





## Section 2 Imagery consent

From time to time Special Olympics Ireland, may undertake marketing and communications activities in order to promote the organisation for the purposes of, but not limited to events, competition, fundraising, awareness and sponsorship. The section below seeks your consent in the use of imagery, in the form of photography and video, 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\*

Print Name \_\_\_\_\_ Signature \_\_\_\_\_

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

\* Please note that in this case it may be impossible to prevent the athlete from being present in a group or crowd shot e.g. for special events, local or Island wide competitions, an award ceremony or similar large scale event. However we will avoid the individual identification of the athlete in a group, team photograph or images.

### 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 their 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 their consent or make their own arrangements for treatment because of their 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 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: [Redacted]

Signature: [Redacted]

Date: [Redacted] / [Redacted] / [Redacted]
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: [Redacted]

Signature: [Redacted]

Date: [Redacted] / [Redacted] / [Redacted]
DD MM YYYY

State your relationship to the athlete:

Parent [Redacted]

Guardian [Redacted]

Next of Kin [Redacted]

Other [Redacted]

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

[Redacted] 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 they have applied to participate in, and has taken appropriate medical advice in relation to their 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: [Redacted]

Signature: [Redacted]

Date: [Redacted] / [Redacted] / [Redacted]
DD MM YYYY

State your relationship to the athlete:

Parent [Redacted]

Guardian [Redacted]

Next of Kin [Redacted]

Other [Redacted]

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 [Redacted], (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 they have applied to participate in, and has taken appropriate medical advice in relation to their 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: [Redacted]

Signature: [Redacted]

Date: [Redacted] / [Redacted] / [Redacted]
DD MM YYYY

State your relationship to the athlete:

Parent [Redacted]

Guardian [Redacted]

Next of Kin [Redacted]

Other [Redacted]





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

If the 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                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart murmur                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Surgery                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Shortness of breath/dizziness/headache on exercise | <input type="checkbox"/> | <input type="checkbox"/> |
| High cholesterol                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Family history of heart disease                    | <input type="checkbox"/> | <input type="checkbox"/> |

### Diabetes

YES NO

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

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| Insulin Dependant                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Managed by diet alone                              | <input type="checkbox"/> | <input type="checkbox"/> |
| History of Hypoglycaemia                           | <input type="checkbox"/> | <input type="checkbox"/> |
| History of Hyperglycaemia or Diabetic Ketoacidosis | <input type="checkbox"/> | <input type="checkbox"/> |

### Asthma

YES NO

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

- |                    | YES                      | NO                       |
|--------------------|--------------------------|--------------------------|
| Status Asthmaticus | <input type="checkbox"/> | <input type="checkbox"/> |

### Mobility

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

- |                 | YES                      | NO                       |
|-----------------|--------------------------|--------------------------|
| Fully mobile    | <input type="checkbox"/> | <input type="checkbox"/> |
| Wheelchair user | <input type="checkbox"/> | <input type="checkbox"/> |
| part time       | <input type="checkbox"/> | <input type="checkbox"/> |
| full time       | <input type="checkbox"/> | <input type="checkbox"/> |

Assistance needed

Outline the assistance required

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Hearing

Please indicate below

- |                    | YES                      | NO                       |
|--------------------|--------------------------|--------------------------|
| Hearing difficulty | <input type="checkbox"/> | <input type="checkbox"/> |
| Hearing Aid        | <input type="checkbox"/> | <input type="checkbox"/> |

### 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 | <input type="checkbox"/> | <input type="checkbox"/> |
| Left eye vision normal  | <input type="checkbox"/> | <input type="checkbox"/> |
| Wears glasses or lens   | <input type="checkbox"/> | <input type="checkbox"/> |

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

- |          |                          |                          |
|----------|--------------------------|--------------------------|
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| Other    | <input type="checkbox"/> | <input type="checkbox"/> |

Outline any assistive devices/aids used

\_\_\_\_\_

### Dietary requirements

YES NO

If yes, please identify below:

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| Coeliac                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetic                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Vegetarian                                | <input type="checkbox"/> | <input type="checkbox"/> |
| No Pork                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Other dietary restriction please indicate | <input type="checkbox"/> | <input type="checkbox"/> |

\_\_\_\_\_

### Allergies

YES NO

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

- |        | YES                      | NO                       |
|--------|--------------------------|--------------------------|
| Latex, | <input type="checkbox"/> | <input type="checkbox"/> |

Medication YES NO

Name of medication/s allergic to

\_\_\_\_\_  
\_\_\_\_\_

Insects bites or stings

Food

### Behavioural and Mental Health

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

- |                                      | YES                      | NO                       |
|--------------------------------------|--------------------------|--------------------------|
| Self-Injurious behaviour in the past | <input type="checkbox"/> | <input type="checkbox"/> |
| Aggressive behaviour                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Verbal outbursts                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Runs away /absconds                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Withdrawn                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Sexually inappropriate behaviour     | <input type="checkbox"/> | <input type="checkbox"/> |
| Other behaviour                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Depression diagnosed                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Anxiety diagnosed                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Other mental health issues           | <input type="checkbox"/> | <input type="checkbox"/> |

If the athlete needs support to manage their behaviour please provide information to support your athlete at the time the behaviour 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 medications? Yes  No

**Has athlete had COVID-19 infection?** Yes  No

If yes, how would you rate your symptoms?  
*(Tick one option below only)*

**None** :- no symptoms of COVID-19 Yes  No

**Mild** : cough, headache, loss of taste & smell, tiredness that went away within 2 weeks Yes  No

**Moderate** : Shortness of breath on exertion, all over aches /muscle pain Yes  No

**Severe** : hospitalisation for any reason Yes  No

*If you ticked **Yes** to athlete having COVID -19 and have had **moderate or severe symptoms only**, you need a medical clearance certificate from your doctor to allow participation in Special Olympics activities.*

**Has athlete had their Covid-19 vaccination?** Yes  No

**Has athlete had their Covid-19 booster vaccine?** Yes  No

**Tick here  if you are not eligible to receive a Covid-19 vaccination**

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

Date:

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

