



Dear Parent, Athlete or Friend:

Welcome to Special Olympics Kansas! Thank you for taking time to enroll someone you care about in Special Olympics.

Special Olympics is a year-round program of sports training, education, and competition for persons with intellectual disabilities, age eight years and older. The goal of the program is to provide continuing opportunities for the athletes to develop physical fitness, demonstrate courage, experience joy and participate in the sharing of skills and friendship with their families, other athletes and the community.

Enclosed in this Athlete Enrollment Kit is the information and forms you will need to register your athlete for participation in Special Olympics.

Through Special Olympics, athletes gain self-esteem, confidence and discipline, which carry over into other aspects of their lives. For additional information about Special Olympics Kansas, please visit our web site at [www.soks.org](http://www.soks.org)

We look forward to welcoming your athlete into our Special Olympics Kansas family.

Sincerely,

A handwritten signature in black ink that reads "John M. Lair".

John M. Lair  
President & CEO

**Special Olympics Kansas**

5280 Foxridge Drive, Mission, KS 66202 **Tel** 913 236 9290 **Fax** 913 236 9771

**Email** [kso@ksso.org](mailto:kso@ksso.org) **Facebook** @specialolympicskansas **Twitter** @sokansas

[www.ksso.org](http://www.ksso.org)

***Special Olympics Kansas  
Athlete Enrollment***

***Steps to Becoming a registered Special Olympics Kansas athlete:***

1. Complete the **Athlete Registration Paperwork.**

A parent/guardian or adult athlete must sign the release statement.

2. Complete the **Special Olympics Kansas Medical Form.**
3. Arrange for a physical examination and your athlete's medical history to be completed. This can be completed by your regular Physician, a Medical Doctor, Doctor of Osteopathy, Doctor of Chiropractic, Physician's Assistant or Advanced Registered Nurse Practitioner (ARNP). Some Physicians will perform the necessary examination for free or at reduced cost when asked to do so for Special Olympics.

Special Olympics Kansas does accept school physicals or similar physical exam/medical releases that clearly state the athlete is cleared to participate in physical activity and is signed by a medical professional.

4. Keep a copy of all the forms for yourself.
5. Send all of completed original forms to the Special Olympics Kansas Headquarters Office:

**Special Olympics Kansas  
5280 Foxridge Drive  
Mission, KS 66202**

**Fax: 913-236-9771**

**Email: [johnsonm@soks.org](mailto:johnsonm@soks.org).**

6. Once the enrollment forms are completed and received by SOKS the registered athlete is eligible to compete at the local, regional, and state events. SOKS will provide contact information for local teams if required.

# *Special Olympics Kansas*

## *Athlete Enrollment*

### **Definition of Eligibility Statement**

**General Statement of Eligibility.** Special Olympics training and competition is open to every person with intellectual disabilities who is at least eight years of age and who registers to participate in Special Olympics.

**Age Requirements.** There is no maximum age limitation for participation in Special Olympics. Special Olympics Kansas permits children who are at least six years old to participate in soccer skills, basketball skills and low motor track activities at the regional level; however, each Local Program has the discretion to decide what sports they choose to offer. No child may participate in a Special Olympics competition (or be awarded medals or ribbons associated with competition) before his or her eighth birthday.

**Degree of Disability.** Participation in Special Olympics training and competition is open to all persons with intellectual disabilities who meet the age requirements, regardless of the level or degree of that person's disability, and whether or not that person also has other mental or physical disabilities, so long as that person registers to participate in Special Olympics.

**Eligibility Criteria.** A person is considered to have intellectual disabilities for purposes of determining his or her eligibility to participate in Special Olympics if that person satisfies any one of the following requirements:

- (1) The person has been identified by an agency or professional as having intellectual disabilities as determined by their localities; or
- (2) The person has a cognitive delay, as determined by standardized measures such as intelligent quotient or "IQ" testing or other measures which are generally accepted within the professional community as being a reliable measurement of the existence of a cognitive delay; or
- (3) The person has a closely related developmental disability. A "closely related developmental disability" means having functional limitations in both general learning (such as recreation, work, independent living, self-direction, or self-care). However, persons whose functional limitations are based solely on a physical, behavioral, or emotional disability, or a specific learning or sensory disability, are not eligible to participate as Special Olympics athletes.

**Preserving Flexibility in Identifying Eligible Athletes.** SOKS may depart from the eligibility requirements identified above if there are exceptional circumstances which warrant such a departure. **Any questions related to an athlete's eligibility on a secondary school team should be referred to the Kansas State High School Activities Association, (785) 273-5329.**



## SPECIAL OLYMPICS KANSAS ATHLETE REGISTRATION

### 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 is required and asks for contact information and health history.
- WAIVERS, RELEASES AND POLICIES FORM.** This form is the second part of the registration form and goes over risks, use of likenesses, emergency medical care, consent for health program participation, personal information, and other important details about Special Olympics participation. Waivers, releases, and policies help create a safe and supportive environment, ensuring everyone’s health, safety, and dignity are respected.
- ATHLETE REGISTRATION RENEWAL FORM.** Starting in 2026, this form is required annually for all athletes participating in Special Olympics. The purpose of a yearly Athlete Registration Renewal Form is to update and capture any changes in an athlete’s health or medication. This ensures that the most current information is on file, helping coaches and medical personnel provide appropriate care and support, and ensuring the safety and well-being of the athlete during participation. This form is due prior to an athlete’s first competition in a calendar year.
- MEDICAL FORM.** This form must be completed and signed by a Licensed Medical Practitioner (for example, Physician, Registered Nurse Practitioner, or Physician Assistant) who is qualified to conduct physical examinations and prescribe medications. It is minimally required for all Regional and World Games events and is designed to identify health concerns and clear an athlete to participate.

The SOKS Medical Form may be current for up to four years. A Medical Form should be submitted to headquarters prior to athlete participation in training and must be submitted prior to SOKS hosted competition (regional, state or other).

<u>Medical Received</u>	<u>Medical Expires</u>
January 1, 2022-December 31, 2023	December 31, 2025
January 1, 2024-December 31, 2024	December 31, 2027
January 1, 2025-December 31, 2025	December 31, 2028
January 1, 2026-December 31, 2026	December 31, 2029

Please submit registration and medical forms to your Regional Director or the SOKS state office.

If you have any other questions, please contact Special Olympics Kansas at 913-236-9290 or [pr@soks.org](mailto:pr@soks.org).

Please submit registration forms to your Regional Director or to the Special Olympics Kansas state office:

5280 Foxridge Drive, Mission, KS 66202

Email to [johnsonm@soks.org](mailto:johnsonm@soks.org) or Fax to 913-236-9771

# U.S. Athlete Registration Form

Special Olympics



Required for all athletes participating in Special Olympics.

Local Special Olympics Program: \_\_\_\_\_

**Athlete Information - To be completed by the athlete or parent/guardian/caregiver.**

First name: \_\_\_\_\_ Last name: \_\_\_\_\_ Middle name: \_\_\_\_\_

Date of birth (dd/mm/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: Female Male Other

Email: \_\_\_\_\_ Phone number: \_\_\_\_\_ Mobile Landline

Home address: \_\_\_\_\_

**Optional – Check all that apply:**

Race / Ethnicity	American Indian / Alaskan Native	Asian American		
	Black / African American	Hispanic / Latino		
	Middle Eastern / North African	Native Hawaiian / Other Pacific Islander		
	White / Caucasian	Unknown		
	Other: _____	Prefer not to answer		
Language(s) Spoken by Athlete	English	French	Spanish	American Sign Language (ASL)
	Other (please list): _____			

**Parent/Guardian Information - Required if minor or otherwise has a legal guardian.**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Relationship to athlete: \_\_\_\_\_

Email: \_\_\_\_\_ Phone number: \_\_\_\_\_ Mobile Landline

Home address: \_\_\_\_\_

**Emergency Contact** *Same as Parent/Guardian*

First name: \_\_\_\_\_ Last name: \_\_\_\_\_ Phone number: \_\_\_\_\_ Mobile Landline

Relationship to athlete: Parent/guardian Caregiver Family member Healthcare provider Coach Other

**Associated Conditions - Mandatory**

Associated Conditions	Autism	Cerebral Palsy	Down Syndrome	Fetal Alcohol Syndrome
	Marfan Syndrome	Spina Bifida	Epilepsy	Fragile X Syndrome
	Other	Unknown		
Please specify other known intellectual disability diagnoses:				

**Assistive Devices and Accommodations - Do you use any of the following? Check all that apply:**

Mobility	Walker	Braces or crutches	Wheelchair	Removable orthotics
	Prosthetics	None		
Lifestyle Aids	CPAP	Dentures	Glasses, contact lenses, or protective eyewear	
	None			
Communications	Hearing Aid	Communication devices	Sign Language	None
Medical Devices	Implantable cardioverter defibrillator (ICD)	Implantable device for seizure management		
	VP Shunt	Pacemaker	None	

Do you have a specific dietary requirement?	Yes	No	If yes, please specify:
Do you use other assistive devices?	Yes	No	If yes, please specify:

**General Health Questions**

Do you have a heart condition?	Yes	No
Do you have asthma?	Yes	No
Do you have diabetes that requires you to take insulin?	Yes	No
Do you have a vision impairment?	Yes	No
Do you have a hearing impairment?	Yes	No
Do you have a bleeding disorder?	Yes	No
Has a doctor ever limited your participation in sports?	Yes	No
Do you have epilepsy or any type of seizure disorder?	Yes	No
Do you have sickle cell disease?	Yes	No

Have you ever had a concussion?	Yes	No	If yes, please specify how many in your lifetime: _____ Date of last one (mm/yyyy): _____
Do you have behavioral, mental health, and/or sensory conditions?	Yes	No	If yes, please specify:
Do you have severe allergies that requires the use of an EpiPen?	Yes	No	If yes, please specify if it is to any of the following: Insect stings                      Medication/drugs Food                                      Latex Other (please specify): _____

**Medication and Treatment - Please list:**

Are you taking any prescription or over-the-counter medications or treatments? (Including birth control pills, insulin, multivitamins allergy shots or pills, EpiPen, asthma inhalers, epilepsy medication, anti-inflammatory medication, supplements of any kind. etc.)

Yes                      No

**If yes, please list:**

Medication, Vitamin, or Supplement Name	Dosage	Times per day

Medication, Vitamin, or Supplement Name	Dosage	Times per day

Name of person completing the form: \_\_\_\_\_

Today's date (dd/mm/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Is this form being completed by someone other than the athlete?                      Yes                      No

If yes, please select the relationship to athlete:

Relationship to athlete:      Parent/guardian                      Caregiver                      Family member                      Healthcare provider                      Coach                      Other

***Special Olympics encourages all participants to get a yearly physical examination.***

## WAIVERS, RELEASES, AND POLICIES

Please read the following information and check boxes fully before signing.

I agree to the following:

- 1. Ability to Participate.** I am physically able to take part in Special Olympics activities, and will abide by all applicable rules, requirements and codes of conduct.
- 2. Likeness Release.** I give permission to Special Olympics, Inc., Special Olympics games organizing committees, Special Olympics accredited Programs (collectively "Special Olympics"), as well as official Special Olympics supporters and partners that have authorization from Special Olympics, to use my likeness, photo, video, name, voice, words, biographical information and similar or related material (my "likeness") to promote Special Olympics and raise funds for Special Olympics. I understand that my likeness may be used in all forms of media in local or global campaigns – including those by supporters and partners of Special Olympics – but understand that my likeness will not be used to endorse commercial products or services. I understand that I will not be compensated for the use of my likeness.
- 3. 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.
  - I do not consent to blood transfusions.(If either box is marked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)
- 4. Overnight Stay.** For some events, overnight accommodations may be required. If I have questions, I will contact my Special Olympics Program.
- 5. 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 have the right to decline Health programming treatment (which is different from sideline or emergency medical care) at any time."
- 6. 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](http://www.SpecialOlympics.org/Privacy-Policy).

### **SYMPTOMS FOR SPINAL CORD COMPRESSION and ATLANTOAXIAL INSTABILITY (For athlete with Down syndrome only)**

If I (or the athlete) have been diagnosed with or experienced any of the following symptoms that have increased in severity over the past three years – difficulty controlling bowels or bladder; numbness or tingling in legs, arms, hands, or feet; weakness in arms, legs, hands or feet; burner/stinger/pinches nerve, pain in neck, back shoulders, arms, hands, buttocks, legs or feet; spasticity or paralysis – I must obtain a review and permission from a licensed medical practitioner to train and/or participate in Special Olympics activities.

**WAIVER AND RELEASE OF LIABILITY / ASSUMPTION OF RISK / INDEMNIFICATION**

In consideration of being allowed to participate in any way in Special Olympics activities, the undersigned acknowledges, appreciates, and agrees that:

1. While particular rules and personal discipline may reduce this risk, the risk of illness (including communicable diseases), injury (including concussion), disability, and death does exist;
2. If I observe 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 Special Olympics representative immediately; and,
3. **I understand the risks involved with participation in Special Olympics activities. I fully accept and assume all risks and all responsibility for losses, costs, and damages I may incur as a result of my participation. To the fullest extent of the law, I release and agree not to sue any Special Olympics organization, its directors, agents, volunteers, and employees, other participants, sponsoring agencies, sponsors, advertisers, and, if applicable owners and lessors of premises on which any Special Olympics activity is occurring ("Releasees") related to any liabilities, claims, or losses on my account caused or alleged to be caused in whole or in part by the Releasees even if arising from the negligence of the Releasees. I have read this release of liability and assumption of risk provision, fully understand its terms, acknowledge that I have given up substantial rights by signing it, and sign it freely and voluntarily without any inducement. I further agree that if, despite this release, I, or anyone on my behalf, makes a claim against any of the Releasees, I will indemnify and hold harmless each of the Releasees from any such liabilities, claims, or losses as the result of such claim. I agree that if any part of this form is held to be invalid, the other parts shall continue in full force and effect.**

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 (dd/mm/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

**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 (dd/mm/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Printed Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**EVALUATION AND RESEARCH  
(Optional)**

Special Olympics wants to help our athletes and their families stay healthy and happy. We may take part in research studies and would share information for your potential participation. All studies will be checked by the Special Olympics Chief Health Officer.

Would you or your family be interested in learning about research studies?

Yes                  No



# Athlete Medical Form



To be completed by a Licensed Medical Practitioner qualified to conduct physical exams and prescribe medications. If necessary, please use additional pages to list anything else Special Olympics should know about this athlete.

Athlete first and last name: \_\_\_\_\_

Date of birth (dd/mm/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Height (in/cm)	Weight (lb/kg)	Waist Circumference (in/cm)	Temperature (°F/°C)	Pulse (bpm)	O2Sat (%)	Blood Pressure (mmHG)		Vision (out of 20)	
						systolic	diastolic	os	od

Does the athlete present with any of the following?							
High Blood Pressure	Yes	No		Coeliac Disease	Yes	No	Unknown
Kidney Disease	Yes	No	Unknown	Osteoporosis	Yes	No	Unknown
Anemia	Yes	No	Unknown	Non-verbal	Yes	No	

Has any family member or relative died of heart problems or of sudden death before age 50?	Yes	No
Was the athlete born without or missing a kidney, an eye, a testicle, or any other organ?	Yes	No

Does the athlete have any past surgeries?	Yes	No	Unknown
Did the athlete ever have an abnormal Electrocardiogram (EKG) or Echocardiogram (ECHO)?	Yes	No	Unknown
Did the athlete ever have any broken bones or dislocated joints?	Yes	No	Unknown
Does the athlete have liver disease?	Yes	No	Unknown
Does the athlete have lung disease?	Yes	No	Unknown
Does the athlete have heart disease?	Yes	No	Unknown

Medical		
Eyes, ears, nose, and throat: include pupils, hearing	Normal	Abnormal
Heart: Include murmurs (auscultation standing, auscultation supine, and ± valsalva maneuver)	Normal	Abnormal
Lungs	Normal	Abnormal
Abdomen	Normal	Abnormal
Skin: HSV, MRSA, or tinea corporis	Normal	Abnormal
Neurological	Normal	Abnormal

Musculoskeletal					
Neck	Normal	Abnormal	Hip and thigh	Normal	Abnormal
Back	Normal	Abnormal	Knee	Normal	Abnormal
Shoulder and arm	Normal	Abnormal	Lower leg and ankle	Normal	Abnormal
Elbow and forearm	Normal	Abnormal	Foot and toes	Normal	Abnormal
Wrist, hand, and fingers	Normal	Abnormal			

Additional findings for any of the above conditions:

**Medical Physical Examination - To be completed by practitioner only.**

**MEDICAL ELIGIBILITY FOR SPORT (TO BE COMPLETED BY PRACTITIONER ONLY)**

*Licensed Medical Practitioner: It is recommended that the practitioner review items on the medical history with the athlete or their guardian, prior to performing the physical exam. If further medical evaluation is warranted, the practitioner must refer the athlete to a specialist and reassess the results from this examination to determine eligibility for participation.*

Medically eligible for all sports or for sports listed: \_\_\_\_\_ without restriction.

Medically eligible for all sports or for sports listed: \_\_\_\_\_

with recommendations for further evaluation or treatment of: \_\_\_\_\_

Not medically eligible pending further evaluation of: \_\_\_\_\_

Not medically eligible to participate in the following sports: \_\_\_\_\_

Not medically eligible for any sports

I have examined the athlete named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of licensed medical practitioner (print or type): \_\_\_\_\_

Date (dd/mm/yyyy): \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Signature of licensed medical practitioner: \_\_\_\_\_

NPI or License number: \_\_\_\_\_

License type (MD, DO, NP, or PA): \_\_\_\_\_