APPLICATION

ATHLETE BIOGRAPHY

NAME : (first) _____ (m.i.) ___ (last)_____

DATE OF BIRTH: _____-_____-_____

ADDRESS: (street) _____

(city,state,zip) _____

PHONE (____)-_____-_____ E-MAIL - _____

CONTACT INFROMATION: (parent/guardian) RELATIONSHIP _____

NAME: _____

ADDRESS: (street)_____

(city,state,zip) _____

PHONE: ( )- -_____ E-MAIL_____

ARE YOU EMPLOYED? Yes _____ No ____ Where? _____

ARE YOU A STUDENT? Yes _____ No _____ Where?_____

HOW MANY YEARS HAVE YOU BEEN IN SPECIAL OLYMPICS? _____

WHICH SPORTS HAVE YOU COMPETED IN? _____

_____

WHICH SPORT IS YOUR FAVORITE? _____

WHICH SPORTS WOULD YOU LIKE TO COMPETE IN? _____

_____

WHAT IS YOUR FAVORITE..... Movie _____ Music _____

TV Shows _____ Hobby _____

Food _____

IS THERE ANYTHING ELSE YOU WANT PEOPLE TO KNOW ABOUT YOU?

_____

_____

MEDICAL OVERVIEW

CHECK ALL THAT APPLY:

ADHD _____ Autism _____ Cerebral Palsey _____ Down Syndrome _____ Fetal Alcohol Syndrome _____ Fragile X Syndrome _____ Seizures _____
Other Diagnosis, please list _____

DOES ATHLETE HAVE OR USE ANY OF THE FOLLOWING DEVICES:

Braces _____ C-PAP _____ Colostomy _____ Crutches/Walker ___
Communication device _____ Dentures _____ G-tube/ J-tube _____
Glasses/ contacs _____ Hearing aid(s) _____ Implanted device _____
Inhaler _____ Pacemaker _____ Removable prosthetic _____
Splints _____ Wheelchair _____ Other _____

ALLERGIES
Please List

Food
_____
Medications
_____
Insects _____
Latex _____ Other _____

CHRONIC OR ACUTE MEDICAL CONDITIONS / INFECTIONS

_____
_____
__

Abnormal EKG Yes ___ No ___ Abnormal EEG Yes ___ No ___

Has athlete ever been limited by a physician for any sport? Yes ___ No ___
If yes please explain _____

Special Dietary Needs _____

MEDICATIONS,VITAMINS, OR DIETARY SUPPLEMENTS
Please List

Medication	Dosage	Times per day

Please use back of sheet for additional medications

Does Athlete Self Medicate? Yes ____ No ____

HISTORY

CHECK ALL THAT APPLY

Bed wetting _____ Claustrophobic _____ Depression _____
Hepatitis _____ Joint Instability _____ Non-verbal _____
Recent fracture _____ Recent surgery _____ Other _____

TRAVEL

PHYSICAL DISCOMFORT

Motion sickness _____
Cramps _____
Headaches _____

EMOTIONAL DISCOMFORT

Homesickness _____
Anxiety _____
Mood swings _____

Has athlete traveled without family / caregiver? Yes ____ No _____
Is athlete able to carry own luggage? Yes ____ No ____

SELF HELP SKILLS

WHAT LEVEL OF SUPPORT DOES ATHLETE REQUIRE FOR THE FOLLOWING?

#1 = Minimal. Athlete relatively independent

#2 = Moderate. Needs supervision within group, ie: 4 athletes to 1 coach

#3 = Significant. 1 on 1

Dressing _____ Grooming _____ Toileting _____ Meals _____

How long does athlete take to get up and ready in the morning? _____

BEHAVIOR

CHECK ALL THAT APPLY AND EXPLAIN CONDITIONS WHEN THEY OCCUR AND WHAT HELPS TO DEFUSE SITUATION

- Bites self and/or others _____
- Difficulty changing routine _____
- Difficulty taking directions _____
- Elevated emotional needs... cries, becomes visibly upset _____
- Elevated sexual interest _____
- Exaggerates pain / illness _____
- Excessive cursing ? vulgarity _____
- Excessive physical touching _____
- Hits self and / or others _____
- Overly dependent on others _____
- Overly fearful _____
- Pulls hair, own and / or others _____
- Resistant to change in diet _____
- Seeks steady entertainment _____
- Teases /bullies others _____
- Temper tantrums _____
- Throws objects _____
- Uncomfortable in crowds _____
- Wanders, runs from group/ sleepwalks _____
- Able to sit and occupy self for extended periods of time _____
- Others _____