# MASONIC UNIFIED CHAMPION CLUB

**Dear Unified Athletes, Parents, and Guardians:**

Thanks to the support of the Maine Masonic Charitable Foundation and the Special Olympics Unified Program we are thrilled to offer the very first Unified Champion Club Program. Through the power of sports, people with intellectual disabilities discover new strengths, abilities, skills and success. Participation in this program helps athletes find joy, confidence and fulfillment — both on the playing field and in life. You will inspire people in your communities and elsewhere to open their hearts to a wider world of human talents and potential.

To register to become an AYCC Unified Club Athlete, please complete the enclosed forms:

- ☐ **ATHLETE RELEASE FORM.** Please read the form in its entirety, print the athlete's name, sign, and date accordingly.
- ☐ **ATHLETE MEDICAL FORM.** This Form is designed to identify health concerns that are more common among people with intellectual disabilities. Page 1 Demographics and Health History sections on page 1 may be completed by Parent/Caregiver. Page 2 of the Athlete Medical Form must be completed and signed by a medical professional. Athlete Medical forms must be submitted every three years from the date of the medical professional's signature, unless Athlete medical information has changed since last submitted medical.
- ☐ **ATHLETE EMERGENCY CARE REFUSAL FORM.** Only complete this form if the athlete does not consent to emergency medical care on religious or other grounds.
- ☐ **ALL ATHLETES MUST ADHERE TO ATHLETE CODE OF CONDUCT.** Please review this form and sign in agreement.

**Please submit completed Athlete Registration forms (original) to:**

- **BY EMAIL:** ccontigiani@clubaycc.org
- **FX:** 1-207-861-8016
- **BY MAIL:** AYCC, 126 North Street, Waterville, ME 04901 Attn: Cassie Contigiani

***Thank you!***

**We are excited you are part of the Unified Champion Movement!**

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I want to take part in the AYCC Unified Club Programming and agree to the following:

1. **Able to Participate.** I am able to take part in the AYCC Unified Club Program. I know there is a risk of injury.

2. **Photo Release.** The AYCC, Special Olympics and Maine Masonic Charitable Foundation organizations may use my picture, video, name, voice, and words to promote Unified Club Programming.

3. **Emergency Care.** I consent to medical care if needed in an emergency, unless I check one of these boxes:

   ☐ I have a religious or other objection to receiving medical treatment.
   ☐ I consent to emergency medical care, but I do not consent to blood transfusions.
   (If either box is checked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)

4. **Health Programs.** If I take part in a health program, I consent to health activities, exams, and treatment. This should not replace regular health care. I can say no to treatment or anything else any time.

5. **Personal Information.** I understand my information may be used and shared by The AYCC and Special Olympics to:
   - Make sure I am eligible and can participate safely;
   - Run trainings and events and share results;
   - Put my information in a computer system;
   - Provide health treatment, make referrals, consult doctors, and remind me about follow-up services;
   - Research, share, and respond to needs of Unified Club athletes (identifying information removed if shared publicly); and
   - Protect health and safety, respond to government requests, and report information required by law.

   I can ask to see and change my information. I can ask to limit how my information is used.

6. **Concussions.** I understand the risk of concussions and continuing to play sports with a concussion. I may have to get medical care if I have a suspected concussion. I also may have to wait 7 days or more and get permission from a doctor before I start playing sports again.

**ATHLETE NAME:** _____

**ATHLETE SIGNATURE** (required if over 18 years old and signing on own behalf)

I have read and understand this release. If I have questions, I will ask. By signing, I agree to this form.

Participant Signature: _____ Date: _____

**PARENT/GUARDIAN SIGNATURE** (required if under 18 years old or has a legal guardian)

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: _____

Printed Name: _____ Relationship: _____

Maine Masonic Charitable FOUNDATION

AYCC Alfond Youth & Community Center

Special Olympics Maine

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# ATHLETE MEDICAL FORM



## DEMOGRAPHICS

Athlete's Social Security # _____ _____ _____ (if US Citizen)

☐ Male ☐ Female

Date of Birth (month/day/year) _____/_____/_____

Athlete's Name _____

Athlete's Address _____

Athlete's Home Phone # _____

Parent/Guardian's Name _____

Parent's Work Phone # _____

Parent/Guardian's Address (if different than athlete) _____

Parent's Home Phone # _____

Emergency Contact (if other than parent/guardian) _____

Emergency Contact's Phone # _____

Health/Accident Insurance Company _____

Policy # _____

## HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | *Heart disease / heart defect / high blood pressure | ☐ | ☐ | Allergy: |
| ☐ | ☐ | *Chest pain | ☐ | ☐ | Medicines: _____ |
| ☐ | ☐ | *Seizures / epilepsy/fainting spells | ☐ | ☐ | Food: _____ |
| ☐ | ☐ | *Diabetes | ☐ | ☐ | Insect stings/bites: _____ |
| ☐ | ☐ | *Concussion or serious head injury | ☐ | ☐ | Special diet |
| ☐ | ☐ | *Major surgery or serious illness | ☐ | ☐ | *Asthma |
| ☐ | ☐ | Heat stroke / exhaustion | ☐ | ☐ | Tobacco use |
| ☐ | ☐ | *Blindness / visual problem | ☐ | ☐ | Easy bleeding |
| ☐ | ☐ | Contact lenses / glasses | ☐ | ☐ | Emotional / psychiatric / behavioral |
| ☐ | ☐ | Hearing loss / hearing aid | ☐ | ☐ | Sickle cell trait or disease |
| ☐ | ☐ | Bone or joint problem | ☐ | ☐ | Immunizations up to date |
| | | Most recent tetanus immunization ___/___/___ | ☐ | ☐ | Other _____ |

(*) Requires physical examination

**Medications:**

Print medication name, amount, date prescribed and number of times per day medication is given

| Medication Name | Dosage | Date Prescribed. | Times per day | Medication Name | Dosage | Date Prescribed. | Times per day |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

Signature Parent/caregiver/adult athlete _____ Date ___/___/___

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# ATHLETE MEDICAL FORM



## ATLANTO-AXIAL INSTABILITY ASSESSMENT FOR ATHLETES WITH DOWN SYNDROME

EXAMINER S NOTE: If the athlete has Down syndrome, Special Olympics requires a full radiological examination establishing the absence of Atlanto-axial Instability before he/she may participate in sports or events which, by their nature, may result in hyperextension, radical flexion or direct pressure on the neck or upper spine. The sports and events for which such a radiological examination is required are: judo, equestrian sports, gymnastics, diving, pentathlon, butterfly stroke and diving starts in swimming, high jump, alpine skiing, snowboarding, squat lift, and football team competition (soccer).

Yes No

☐ ☐ Has an x-ray evaluation for atlanto-axial instability been done?

☐ ☐ If yes, was it positive for atlanto-axial instability? (positive indicates that the atlanto-dens interval is 5mm or more)

## PHYSICAL EXAMINATION

Blood pressure: / Weight: Height:

| Normal/Abnormal | | | Normal/Abnormal | | | Normal/Abnormal | | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Vision | ☐ | ☐ | Cardiovascular system | ☐ | ☐ | Cranial nerves |
| ☐ | ☐ | Hearing | ☐ | ☐ | Respiratory system | ☐ | ☐ | Coordination |
| ☐ | ☐ | Oral cavity | ☐ | ☐ | Gastrointestinal system | ☐ | ☐ | Reflexes |
| ☐ | ☐ | Neck | ☐ | ☐ | Genitourinary system | | | |
| ☐ | ☐ | Extremities | ☐ | ☐ | Skin | | | |

Other: _____

Primary MR Etiology/Category: (If known) _____

I have reviewed the above health information and have performed the above examination on this athlete within the past 6 months and certify that the athlete can participate in Unified Club Programming.

RESTRICTIONS: _____

EXAMINER S SIGNATURE: _____ Date / /

EXAMINER S NAME: _____

ADDRESS: _____

_____ PHONE: _____

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Special Olympics Maine

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# SPECIAL RELEASE FORM

(SPECIAL RELEASE CONCERNING SPINAL CORD COMPRESSION AND ATLANTO-AXIAL INSTABILITY)

**Instructions:** Only complete this form if symptoms of spinal cord compression or Atlanto-axial instability were found in a pre-participation examination and a doctor then provided clearance for participation following a neurological evaluation.

I agree to the following:

1. **Spinal Cord Compression Symptoms.** In a pre-participation examination, a licensed medical professional found symptoms that might be the result of spinal cord compression or Atlanto-axial instability.

2. **Neurological Evaluation.** After a neurological evaluation, a qualified doctor concluded that:
   - The cause of the symptoms will not result in additional risk of neurological injury due to participation in sports, and
   - Participation in AYCC Unified Club Program activities is safe without restrictions or with restrictions that will be shared with Special Olympics and followed.

3. **Liability Release.** I acknowledge that I have been informed of the findings and determinations of the physician. I release and hold harmless AYCC Unified Club Program from all claims in connection with possible spinal cord compression or Atlanto-axial instability.

**ATHLETE NAME:** _____

**ATHLETE SIGNATURE** (required if Athlete is over 18 years old and is signing on own behalf)

I have read and understand this release. By signing, I agree to this release.

Athlete Signature:_____ Date: _____

**PARENT/GUARDIAN SIGNATURE** (required if Athlete is under 18 years old or has a legal guardian)

I am a parent or guardian of the Athlete and am authorized to enter into this release on the Athlete's behalf. I have read and understand this release and have explained the contents to the Athlete as appropriate. By signing, I agree to this release on my own behalf and on behalf of the Athlete. This Release shall be binding upon me, the Athlete and our respective heirs and legal representatives.

Parent/Guardian Signature:_____ Date: _____

Printed Name:_____ Relationship: _____

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## EMERGENCY MEDICAL CARE REFUSAL FORM

### TO BE COMPLETED BY ATHLETE SIGNING ON OWN BEHALF

**Instructions:** Only complete this form if you do not consent to emergency medical care on religious or other grounds and have checked a box under the Emergency Care provision on the Athlete Release Form.

**I,_____, am at least 18 years old and agree to the following:**

1. **No Consent to Emergency Medical Care.** I understand that the Alfond Youth & Community Center (AYCC)'s standard registration form requires athletes or their parents or guardians to consent to emergency medical care for the athlete if needed in an emergency. Based on religious beliefs or other reasons I am not consenting to emergency medical care.

**YOU MUST CHECK THE BOX AND WRITE YOUR INITIALS NEXT TO ONE STATEMENT TO CONFIRM YOUR INTENT:**

☐ **I DO NOT CONSENT TO ANY KIND OF MEDICAL TREATMENT, EVEN IN A LIFE-THREATENING EMERGENCY. INITIALS: _____**

☐ **I DO NOT CONSENT TO BLOOD TRANSFUSIONS, EVEN IN A LIFE-THREATENING EMERGENCY. I CONSENT TO ALL OTHER KINDS OF EMERGENCY MEDICAL CARE. INITIALS: _____**

2. **Printed Instructions.** I agree to carry printed instructions that describe my religious or other objections to medical treatment and how I wish Special Olympics to respond if I get sick or hurt and cannot speak for myself. I agree to carry these printed instructions with me at all times during my participation in any AYCC activity, including during meal times, in overnight accommodations, at training sessions and competitions, and during travel to and from AYCC activities.

3. **Friend or Family Accompaniment.** I agree that I will be accompanied by an adult friend or family member at all times during my participation in any AYCC activity, so that this person can take personal responsibility for me during a medical emergency where I am unable to speak for myself. I understand that if this friend or family member is not present at all times, I will not be permitted to participate in AYCC activities, and that no exceptions will be made.

4. **No Guarantee.** I understand that AYCC cannot guarantee that emergency medical care will be withheld if I am not carrying the printed instructions **or** the accompanying adult is not present and actively taking personal responsibility for me during a medical emergency where I am unable to speak for myself.

5. **Liability Release.** I release AYCC, its employees, and its volunteers from all claims that may arise out of taking or failing to take measures to provide me with emergency medical care. I am agreeing to this release because I have refused, knowingly and voluntarily, to give AYCC permission to take emergency measures, and I am expressly directing AYCCs not to do so on religious or other grounds.

**I have read and understand this release. By signing, I agree to this release.**

Athlete Signature:_____ Date: _____

**By signing, I agree to accompany the Athlete during all AYCC activities and take personal responsibility for the Athlete during an emergency. I understand the extent to which the Athlete does not consent to emergency medical care and agree to act in accordance with the Athlete's wishes as I understand them.**

Signature of Accompanying Adult:_____ Date: _____

Printed Name:_____ Relationship: _____