



Return to Activity Forms: Athlete Checklist

We are following Special Olympics International (SOI) guidance around returning to activity. [Please click here to view the updated SOI Return to Activities Protocol](#). We currently fall in the “low risk”/green category.

Practices may start as soon as coaches are able to begin and once athletes have submitted all required paperwork. The typical 6-week training period is flexible this year as circumstances are different compared to normal times. Completed forms can be scanned and emailed to paperwork@vtso.org or mailed to Special Olympics Vermont, 16 Gregory Drive, Suite 2, South Burlington, VT 05403.

What do you need in order to start practicing?

- [Athlete Registration Form & Medical Form](#) (Expires every 3 years)
 - You can complete the first portion of the athlete registration form online and then download/print the Medical Form portion to bring to your doctor's office for them to complete the physical exam portion of the medical form.
- [Program Information Form](#)
- [SOVT COVID-19 Waiver](#)
- [Participant Code of Conduct & Risk Waiver](#)

ATHLETE REGISTRATION FORM

Special Olympics
Vermont



County/Local Program: _____

Are you a new athlete to Special Olympics or Re-Registering? ☐ New Athlete ☐ Re-Registering

ATHLETE INFORMATION

First Name:	Middle Name:	
Last Name:	Preferred Name:	
Date of Birth (mm/dd/yyyy):	<input type="checkbox"/> Female	<input type="checkbox"/> Male
Race/Ethnicity (Optional):		
<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Two or More Races		
<input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander		
<input type="checkbox"/> White <input type="checkbox"/> Hispanic or Latino (specific origin group: _____)		
Language(s) Spoken in Athlete's Home (Optional): Check all that apply		
<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (please list): _____		
Street Address:		
City:	State:	Postal Code:
Phone:	E-mail:	
Sports/Activities:		
Athlete Employer, if any (Optional):		
Does the athlete have the capacity to consent to medical treatment on his or her own behalf? <input type="checkbox"/> Yes <input type="checkbox"/> No		

PARENT / GUARDIAN INFORMATION (required if minor or otherwise has a legal guardian)

Name:		
Relationship:		
<input type="checkbox"/> Same Contact Info as Athlete		
Street Address:		
City:	State:	Postal Code:
Phone:	E-mail:	

EMERGENCY CONTACT INFORMATION

<input type="checkbox"/> Same as Parent/Guardian	
Name:	
Phone:	Relationship:

PHYSICIAN & INSURANCE INFORMATION

Primary Care Physician Name:	
Physician Phone:	
Insurance Company:	Insurance Policy Number:
Insurance Group Number:	

Athlete Medical Form – HEALTH HISTORY

(To be completed by the athlete or parent/guardian/caregiver and brought to exam)



Athlete First & Last Name: _____ Preferred Name: _____

Athlete Date of Birth (mm/dd/yyyy): _____ Female Male

STATE PROGRAM: _____ E-mail: _____

ASSOCIATED CONDITIONS - Does the athlete have (check any that apply):

Autism	Down Syndrome	Fragile X Syndrome
Cerebral Palsy	Fetal Alcohol Syndrome	
Other Syndrome, please specify: _____		

ALLERGIES & DIETARY RESTRICTIONS

No Known Allergies
Latex
Medications: _____
Insect Bites or Stings: _____
Food: _____

ASSISTIVE DEVICES - Does the athlete use (check any that apply):

Brace	Colostomy	Communication Device
C-PAP Machine	Crutches or Walker	Dentures
Glasses or Contacts	G-Tube or J-Tube	Hearing Aid
Implanted Device	Inhaler	Pacemaker
Removable Prosthetics	Splint	Wheel Chair

List any special dietary needs:

SPORTS PARTICIPATION

List all Special Olympics sports the athlete wishes to play:

Has a doctor ever limited the athlete's participation in sports?

No Yes If yes, please describe:

SURGERIES, INFECTIONS, VACCINES

List all past surgeries:

Does the athlete currently have any chronic or acute infection?

No Yes If yes, please describe:

Has the athlete ever had an abnormal Electrocardiogram (EKG) or Echocardiogram (Echo)? If yes, describe date and results

Yes, had abnormal EKG

Yes, had abnormal Echo

Has the athlete had a Tetanus vaccine in the past 7 years? No Yes

EPILEPSY AND/OR SEIZURE HISTORY

Epilepsy or any type of seizure disorder No Yes

If yes, list seizure type: _____

If yes, had seizure during the past year? No Yes

MENTAL HEALTH

Self-injurious behavior during the past year	No	Yes	Depression (diagnosed)	No	Yes
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Aggressive behavior during the past year	No	Yes	Anxiety (diagnosed)	No	Yes
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Describe any additional mental health concerns:

FAMILY HISTORY

Has any relative died of a heart problem before age 50? No Yes

Has any family member or relative died while exercising? No Yes

List all medical conditions that run in the athlete's family:

Athlete Medical Form – HEALTH HISTORY

(To be completed by the athlete or parent/guardian/caregiver and brought to Exam)



Athlete's First and Last Name: _____

HAS THE ATHLETE EVER BEEN DIAGNOSED WITH OR EXPERIENCED ANY OF THE FOLLOWING CONDITIONS

Loss of Consciousness	No	Yes	High Blood Pressure	No	Yes	Stroke/TIA	No	Yes
Dizziness during or after exercise	No	Yes	High Cholesterol	No	Yes	Concussions	No	Yes
Headache during or after exercise	No	Yes	Vision Impairment	No	Yes	Asthma	No	Yes
Chest pain during or after exercise	No	Yes	Hearing Impairment	No	Yes	Diabetes	No	Yes
Shortness of breath during or after exercise	No	Yes	Enlarged Spleen	No	Yes	Hepatitis	No	Yes
Irregular, racing or skipped heart beats	No	Yes	Single Kidney	No	Yes	Urinary Discomfort	No	Yes
Congenital Heart Defect	No	Yes	Osteoporosis	No	Yes	Spina Bifida	No	Yes
Heart Attack	No	Yes	Osteopenia	No	Yes	Arthritis	No	Yes
Cardiomyopathy	No	Yes	Sickle Cell Disease	No	Yes	Heat Illness	No	Yes
Heart Valve Disease	No	Yes	Sickle Cell Trait	No	Yes	Broken Bones	No	Yes
Heart Murmur	No	Yes	Easy Bleeding	No	Yes	Dislocated Joints	No	Yes
Endocarditis	No	Yes	If female athlete, list date of last menstrual period: _____					

Describe any past broken bones or dislocated joints

(if yes is checked for either of those fields above):

List any other ongoing or past medical conditions:

Neurological Symptoms for Spinal Cord Compression and Atlanto-axial Instability

Difficulty controlling bowels or bladder	No	Yes	If yes, is this new or worse in the past 3 years?	No	Yes
Numbness or tingling in legs, arms, hands or feet	No	Yes	If yes, is this new or worse in the past 3 years?	No	Yes
Weakness in legs, arms, hands or feet	No	Yes	If yes, is this new or worse in the past 3 years?	No	Yes
Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet	No	Yes	If yes, is this new or worse in the past 3 years?	No	Yes
Head Tilt	No	Yes	If yes, is this new or worse in the past 3 years?	No	Yes
Spasticity	No	Yes	If yes, is this new or worse in the past 3 years?	No	Yes
Paralysis	No	Yes	If yes, is this new or worse in the past 3 years?	No	Yes

PLEASE LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW

(includes inhalers, birth control or hormone therapy)

Medication, Vitamin or Supplement Name	Dosage	Times per Day	Medication, Vitamin or Supplement Name	Dosage	Times per Day	Medication, Vitamin or Supplement Name	Dosage	Times per Day

Is the athlete able to administer his or her own medications? No Yes

Name of Person Completing this Form	Relationship to Athlete	Phone	Email
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Athlete Medical Form – PHYSICAL EXAM

(To be completed by a Licensed Medical Professional qualified to conduct exams & prescribe medications)



Athlete's First and Last Name: _____

MEDICAL PHYSICAL INFORMATION

(To be completed by a Licensed Medical Professional qualified to conduct physical exams and prescribe medications)

Height	Weight	BMI (optional)	Temperature	Pulse	O ₂ Sat	Blood Pressure (in mmHg)		Vision			
cm	kg	BMI	C			BP Right:	BP Left:	Right Vision 20/40 or better	No	Yes	N/A
in	lbs	Body Fat %	F					Left Vision 20/40 or better	No	Yes	N/A
Right Hearing (Finger Rub)	Responds	No Response	Can't Evaluate			Bowel Sounds	Yes	No			
Left Hearing (Finger Rub)	Responds	No Response	Can't Evaluate			Hepatomegaly	No	Yes			
Right Ear Canal	Clear	Cerumen	Foreign Body			Splenomegaly	No	Yes			
Left Ear Canal	Clear	Cerumen	Foreign Body			Abdominal Tenderness	No	RUQ	RLQ	LUQ	LLQ
Right Tympanic Membrane	Clear	Perforation	Infection	NA		Kidney Tenderness	No	Right	Left		
Left Tympanic Membrane	Clear	Perforation	Infection	NA		Right upper extremity reflex	Normal	Diminished		Hyperreflexia	
Oral Hygiene	Good	Fair	Poor			Left upper extremity reflex	Normal	Diminished		Hyperreflexia	
Thyroid Enlargement	No	Yes				Right lower extremity reflex	Normal	Diminished		Hyperreflexia	
Lymph Node Enlargement	No	Yes				Left lower extremity reflex	Normal	Diminished		Hyperreflexia	
Heart Murmur (supine)	No	1/6 or 2/6	3/6 or greater			Abnormal Gait	No	Yes, describe below			
Heart Murmur (upright)	No	1/6 or 2/6	3/6 or greater			Spasticity	No	Yes, describe below			
Heart Rhythm	Regular	Irregular				Tremor	No	Yes, describe below			
Lungs	Clear	Not clear				Neck & Back Mobility	Full	Not full, describe below			
Right Leg Edema	No	1+ 2+ 3+ 4+				Upper Extremity Mobility	Full	Not full, describe below			
Left Leg Edema	No	1+ 2+ 3+ 4+				Lower Extremity Mobility	Full	Not full, describe below			
Radial Pulse Symmetry	Yes	R>L L>R				Upper Extremity Strength	Full	Not full, describe below			
Cyanosis	No	Yes, describe				Lower Extremity Strength	Full	Not full, describe below			
Clubbing	No	Yes, describe				Loss of Sensitivity	No	Yes, describe below			

SPINAL CORD COMPRESSION & ATLANTO-AXIAL INSTABILITY (AAI) (Select one)

Athlete shows **NO EVIDENCE** of neurological symptoms or physical findings associated with spinal cord compression or atlanto-axial instability.

OR

Athlete has neurological symptoms or physical findings that could be associated with spinal cord compression or atlanto-axial instability and **must receive an additional neurological evaluation** to rule out additional risk of spinal cord injury prior to clearance for sports participation.

ATHLETE CLEARANCE TO PARTICIPATE (TO BE COMPLETED BY EXAMINER ONLY)

Licensed Medical Examiners: It is recommended that the examiner review items on the medical history with the athlete or their guardian, prior to performing the physical exam. If an athlete needs further medical evaluation please make a referral below and second physician for referral should complete page 4.

This athlete is **ABLE** to participate in Special Olympics sports without restrictions.

This athlete is **ABLE** to participate in Special Olympics sports **WITH** restrictions. Describe ➡ _____

This athlete **MAY NOT participate** in Special Olympics sports at this time & **MUST** be further evaluated by a physician for the following concerns:

Concerning Cardiac Exam

Acute Infection

O₂ Saturation Less than 90% on Room Air

Concerning Neurological Exam

Stage II Hypertension or Greater

Hepatomegaly or Splenomegaly

Other, please describe:

Additional Licensed Examiner's Notes and Recommended (but not required) Follow-up:

Follow up with a cardiologist

Follow up with a neurologist

Follow up with a primary care physician

Follow up with a vision specialist

Follow up with a hearing specialist

Follow up with a dentist or dental hygienist

Follow up with a podiatrist

Follow up with a physical therapist

Follow up with a nutritionist

Other/Exam Notes:

		Name:	
		E-mail:	
Signature of Licensed Medical Examiner	Exam Date	Phone:	License #:

Athlete Medical Form – MEDICAL REFERRAL FORM

(To be completed by a Licensed Medical Professional only if referral is needed)



Athlete's First and Last Name: _____

This page only needs to be completed and signed if the physician on page three does not clear the athlete and indicates further evaluation is required.

Athlete should bring the previously completed pages to the appointment with the specialist.

Examiner's Name: _____

Specialty: _____

I have been asked to perform an additional athlete exam for the following medical concern(s) - *Please describe:*

Concerning Cardiac Exam

Acute Infection

O₂ Saturation Less than 90% on Room Air

Concerning Neurological Exam

Stage II Hypertension or Greater

Hepatomegaly or Splenomegaly

Other, please describe:

In my professional opinion, this athlete MAY now participate in Special Olympics sports (indicate restrictions or limitations below):

Yes

Yes, but with restrictions (*list below*)

No

Additional Examiner Notes/Restrictions:

Examiner E-mail: _____

Examiner Phone: _____

License: _____

Examiner's Signature

Date

This section to be completed by Special Olympics staff only, if applicable.

This medical exam was completed at a MedFest event?

Yes

No

The athlete is a Unified Partner or a Young Athlete Participant?

Unified Partner

Young Athlete

PARTICIPANT RELEASE FORM

Special Olympics
Vermont



I agree to the following:

1. **Ability to Participate.** I am physically able to take part in Special Olympics activities.
2. **Likeness Release.** I give permission to Special Olympics, Inc., Special Olympics games organizing committees, and Special Olympics accredited Programs (collectively "Special Olympics") to use my likeness, photo, video, name, voice, and words to promote Special Olympics and raise funds for Special Olympics.
3. **Risk of Concussion and Other Injury.** I know there is a risk of injury. I understand the risk of continuing to play sports with or after a concussion or other injury. I may have to get medical care if I have a suspected concussion or other injury. I also may have to wait 7 days or more and get permission from a doctor before I start playing sports again.
4. **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. (Not common.)
 - ☐ I do not consent to blood transfusions. (Not common.)(If either box is marked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)
5. **Overnight Stay.** For some events, I may stay in a hotel or someone's home. If I have questions, I will ask.
6. **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 can say no to treatment or anything else at any time.
7. **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 personal information and creating a profile of me for communications and marketing purposes, including direct digital marketing through email, SMS, social media, and other channels.
 - sharing my personal information with (i) researchers, business partners, public health agencies, and other organizations 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 understand Special Olympics is a global organization with headquarters in the United States of America. I acknowledge that my personal information may be stored and processed in countries outside my country of residence, including the United States. Such countries may not have the same level of personal data protection as my country of residence, and I agree that the laws of the United States will govern your processing of my personal information as provided in this consent.
 - 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.
 - *Sharing of Personal Information.* Personal information may be shared consistent with this form and as further explained in the Special Olympics privacy policy at www.SpecialOlympics.org/Privacy_Policy.aspx.

Athlete Name:	E-mail:
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:
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:
Printed Name:	Relationship:



SOVT Program Information Form

Name

**Parent/Guardian or Care Provider
Name**

What is your affiliation with SOVT?
(ex: athlete, coach, Unified Partner,
volunteer)

Phone Number

Email

**Parent/Guardian or Care Provider
Email (if different from above)**

Address

What is your Local Program Affiliation
(ex. Franklin County, Northshire,
etc.)?

Name of school you currently attend
(if applicable)

**Over the past year, have you been
receiving emails from Special
Olympics Vermont?**

Please check one:

Yes

No

Please check your spam or junk email folders to see if our emails have been landing there instead of your inbox.

Have you received the COVID-19 vaccine?

Yes

No

Please check one:

I am partially vaccinated and plan to become fully
vaccinated

It is not required that you answer the question above, however if you leave the question blank, SOVT will proceed as if you are not vaccinated against COVID-19.

Gender: Please check one:

Female

Male

Other:

Race/Ethnicity:

American Indian / Alaskan Native

Asian American

Hispanic or Latinx

Native Hawaiian or Other Pacific Islander

White or Caucasian

Black or African American

More than one race (check all that apply)

Prefer not to answer

**Languages Spoken in
Athlete's Home (Optional):**

English

Spanish

Other:

Athlete Code of Conduct

Special Olympics is committed to the highest ideals of sport and expects all athletes to honor sports and Special Olympics. All Special Olympics athletes and Unified Sports Partners agree to the following code:

Sportsmanship

- I will practice good sportsmanship.
- I will act in ways that bring respect to me, my coaches, my team and Special Olympics.
- I will not use bad language.
- I will not swear or insult other persons.
- I will not fight with other athletes, coaches, volunteers or staff.

Training & Competition

- I will train regularly.
- I will learn and follow the rules of my sport.
- I will listen to my coaches and the officials and ask questions when I do not understand.
- I will always try my best during training, divisioning and competitions.
- I will not "hold back" in preliminaries just to get into an easier final heat.

Responsibility for My Actions

- I will not make inappropriate or unwanted physical, verbal or sexual advances on others.
- I will not drink alcohol, smoke or take illegal drugs while representing Special Olympics at training sessions, competition or during Games.
- I will not take drugs for the purpose of improving my performance.
- I will obey all laws and Special Olympics rules.

I understand that if I do not obey this Code of Conduct, I will be subject to a range of consequences by my Program or a Games Organizing Committee for any Special Olympics event or activity, up to and including not being allowed to participate.

**I agree to the Athlete Code of Conduct
Above**

Yes

Other comments or questions:

**WAIVER AND RELEASE OF LIABILITY, ASSUMPTION OF RISK AND INDEMNIFICATION
AGREEMENT FOR COMMUNICABLE DISEASES
("Agreement") for
SPECIAL OLYMPICS**

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

1. Participation includes possible exposure to and illness from infectious and/or communicable diseases including but not limited to MRSA, influenza, and COVID-19. While particular rules and personal discipline may reduce this risk, the risk of serious illness and death does exist; and,
2. I KNOWINGLY AND FREELY ASSUME ALL SUCH RISKS, both known and unknown, EVEN IF ARISING FROM THE NEGLIGENCE OF THE RELEASEES or others, and assume full responsibility for my participation; and,
3. I willingly agree to comply with the stated and customary terms and conditions for participation as regards protection against infectious diseases. If, however, I observe and 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 official immediately; and,
4. I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, HEREBY RELEASE AND HOLD HARMLESS Special Olympics, Inc, Special Olympics Vermont their officers, officials, agents, and/or employees, other participants, sponsoring agencies, sponsors, advertisers, and if applicable, owners and lessors of premises used to conduct the event ("RELEASEES"), WITH RESPECT TO ANY AND ALL ILLNESS, DISABILITY, DEATH, or loss or damage to person or property, WHETHER ARISING FROM THE NEGLIGENCE OF RELEASEES OR OTHERWISE, to the fullest extent permitted by law.

I HAVE READ THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IF FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

Name of Participant: _____

Participant Signature: _____

Date signed: _____

FOR PARTICIPANTS OF MINORITY AGE (UNDER AGE 18 AT THE TIME OF REGISTRATION)

This is to certify that I, as parent/guardian, with legal responsibility for this participant, have read and explained the provisions in this waiver/release to my child/ward including the risks of presence and participation and his/her personal responsibilities for adhering to the rules and regulations for protection against communicable diseases. Furthermore, my child/ward understands and accepts these risks and responsibilities. I for myself, my spouse, and child/ward do consent and agree to his/her release provided above for all the Releasees and myself, my spouse, and child/ward do release and agree to indemnify and hold harmless the Releasees for any and all liabilities incident to my minor child's/ward's presence or participation in these activities as provided above, EVEN IF ARISING FROM THEIR NEGLIGENCE, to the fullest extent provided by law.

Name of parent/guardian: _____

Parent guardian/signature: _____

Date signed: _____

COVID-19 Participant Code of Conduct and Risk Assessment Form

Special Olympics



I understand I could get Coronavirus through sports, training, competition and/or any group activity at Special Olympics. I am choosing to participate in sports, competition and/or other Special Olympics activities at my own risk.

During the time these precautions are needed, I agree to the following to help keep me and my fellow participants safe:

- | |
|--|
| <input type="checkbox"/> If I have COVID-19 symptoms, I will stay at home and NOT go to any activities until 7 days after all of my symptoms are over. If I am exposed to COVID-19 and have no symptoms, I must self-quarantine if required by local regulations |
| <input type="checkbox"/> Special Olympics gave me education on Special Olympics rules for COVID-19 and who is at high-risk. |
| <input type="checkbox"/> I know that if I have a high-risk condition, I have more risk that I could get sick or die from COVID-19. If I have a high-risk condition and am not fully vaccinated, I should not go to Special Olympics events in person, until there is little or no Coronavirus in my community. |
| <input type="checkbox"/> I know that before or when I get to a Special Olympics activity, they may ask me some questions about symptoms and exposure to COVID-19. They may also take my temperature. I will answer truthfully and participate fully. |
| <input type="checkbox"/> I will keep at least 6 ft/2m from all participants at all times, when asked |
| <input type="checkbox"/> I will wear a mask at all times while at Special Olympics activities when asked. I may not have to wear it during active exercise. |
| <input type="checkbox"/> I will wash my hands for 20 seconds or use hand sanitizer before any activities. I will wash my hands any time I sneeze, cough, go to the bathroom or get my hands dirty. |
| <input type="checkbox"/> I will avoid touching my face. I will cover my mouth when I cough or sneeze and immediately wash my hands after. |
| <input type="checkbox"/> I will not share drinking bottles or towels with other people. |
| <input type="checkbox"/> I will only share equipment when instructed to. If equipment must be shared, I will only touch the equipment if it is disinfected first. |
| <input type="checkbox"/> If I get or have had COVID, I will not go to any in-person Special Olympics events until 7 days after my symptoms end. I will go to my doctor and get written clearance before returning to any sport or fitness activities. |
| <input type="checkbox"/> I understand that if I do not follow all of these rules, I may not be allowed to participate in Special Olympics activities during this time. |

COVID-19 Participant Code of Conduct and Risk Assessment Form

Special Olympics



I HAVE READ ALL OF THIS AGREEMENT OR HAVE HAD IT READ TO
ME AND AGREE TO FOLLOW THESE ACTIONS.

PARTICIPANT FULL NAME: _____

Phone: _____ **Email:** _____

Circle one: Athlete Unified Partner Coach/Volunteer Family/Caregiver Staff

PARTICIPANT SIGNATURE *(required for adult (age 18+) participants, including adult athlete with capacity to sign documents)*

By signing this, I acknowledge that I have completely read and fully understand the information in this form.

Signature: _____ **Date:** _____

PARENT/GUARDIAN SIGNATURE *(required for participant who is a minor (younger than age 18) or lacks capacity to sign documents)*

I am a parent or guardian of the athlete/participant named above. I have read and understand this form and have explained the contents to the participant as appropriate. By signing, I agree to this form on my own behalf and on behalf of the participant.

Parent/Guardian Signature: _____ **Date:** _____

Printed Name: _____

Relationship: _____

Fact Sheet on Who is at Higher Risk from COVID-19

Special Olympics



**Subject to Change
Version: 6-28-2021**

Who is at higher risk of COVID-19?

COVID-19 is a relatively new disease and information is changing on who is more likely to get COVID-19 and who is will have more complications.

Current clinical guidance and information from the U.S. Centers for Disease Control and Prevention (CDC) and World Health Organization (WHO) lists those at high-risk for severe illness from COVID-19 as:

- Unvaccinated people 60 years and older. Risk increases with age.
- Unvaccinated people with disabilities (resulting from long-standing systemic health and social inequities)

Regardless of age, individuals who are **unvaccinated** and have underlying conditions, such as the following, are or maybe at increased risk of severe illness from COVID-19:

- People with chronic lung disease, chronic obstructive pulmonary disease or moderate to severe asthma, interstitial lung disease, cystic fibrosis, and pulmonary hypertension
- People who have serious heart conditions (including heart failure, coronary artery disease, congenital heart disease, cardiomyopathy, hypertension)
- People who have HIV and/or are immunocompromised
- People with obesity or who are overweight (body mass index [BMI] of 25 or higher). To calculate BMI, refer to:
 - https://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/english_bmi_calculator/bmi_calculator.html
- People with cancer
- People with diabetes (Type 1 and 2)
- People with chronic kidney disease
- People with liver disease
- People with dementia
- People with down syndrome
- People who are pregnant
- People who are smokers, current or former
- People with a substance abuse disorder
- People with sickle cell disease or thalassemia
- People who have had a stroke or cerebrovascular disease

The list may change as evidence is learned. Please review the latest list of conditions that put individuals at increased risk available at the [CDC website \(https://bit.ly/2VEJcSK\)](https://bit.ly/2VEJcSK)

If you are at a high risk and unvaccinated, you may be putting yourself at risk when you return to activities with Special Olympics. But, you may also put your family and your teammates at risk. If you have these conditions, it is strongly recommended that you should not return to Special Olympics in person activities until you are vaccinated or the community transmission in your community is low.

If you have been diagnosed with COVID-19, you should consult with a healthcare professional for written medical clearance before returning to Special Olympics in person activities as serious cardiac, respiratory, and neurological issues may develop as a result of COVID-19.