

### **SOFTBALL ROSTER**

Ī	COUNTY:	Pinellas	ESTIMATED DIVISION:
ŀ	TEAM NAME	Devil Rays	PHONE: 727 864 8976
Ī	HEAD COAC		E-MAIL: WeppnespGeckard, edu
Ī	ADDRESS:	S5 Gth Ave NE #1	CITY/ZIP: 1 St. Petersburg 3370
Tea		Traditional Team Unified Sports® Te	
Age		Pee Wee (8-11 yrs)	
		e oldest player on the team will determine the Age Div	ision of the Team
	Enter "P" for Unified	Athlete Names	•
	Sports® Partner	(Last Name, First Name)	DOB
1		William Duncan	5/25/1970
2	-	Chris Duncan	8/25/1967
3		Richard Cromoton	7/8/1964
4		Kerth Rankin	10/23/1973
5		Steve LaBlance	
6		Richard Green	7/4/1970
7		David Perkinson	9/4/1977
8		Tommy Minnifield	4/6/1966
9		Robert Winland	3/12/1969
10		Darrell Witherspoon	Manharan 6/19/1977
11		Chris Schaer	1/15/1985
12	·	James Stock	4/5/1974
13		Sean Curtis	5/9/1976
14		Amanda Figuerero	
15		Stephanie Schreck	

Maximum # of Players: Traditional Team - 15, Unified Sports® Team - 15, Team Skills - 10 Place a "P" in the appropriate column for all Partners on a Unified Sports® Team

Team composition may not change after Area Level competition.

### DIAGNOSTIC CLINIC 1551 WEST BAY DRIVE LARGO, FL. 33770 (727)581-8767

### C Spine

Patient:

WILLIAM J. DUNCAN

Encounter:

Sep 20 2007 12:00AM

EMRN:

100034

#### **CERVICAL SPINE:**

FINDINGS: The alignment of the cervical spine is intact in the neutral position. Cervical lordosis is preserved. Vertebral heights are maintained. There is straightening of the cervical lordosis in the flexion position. In the extension position, there is approximately 2 mm of retrolisthesis of both C2 and C3.

There is approximately 2 mm between the posterior margin of the anterior arch of C1 and the anterior margin of the odontoid, seen on the neutral, flexed and extension views. No evidence of C1-2 subluxation is seen. End plate osteophyte is producing mild encroachment on the right neural foramen at C3-4 and no other evidence of narrowing is seen. Cervical spine films are otherwise negative.

Brian E. Scanlan, MD

This document has been electronically authenticated by Brian E. Scanlan, MD on 09/21/2007 12:48:13 EDT

BES/MedQ

D: 09/21/2007 09:19:05 Clinic Job ID: 406111 T: 09/21/2007 09:58:58

Internal Job ID: 297838625

### APPLICATION FOR PARTICIPATION (Medical Form)



(must be completed and signed by licensed examiner every 3 years) COUNTY: School/Agency:

SSN: 267167 | 3509 | T-shirt Size: Children: OR Adult:

LAST NAME DUNCAN | FIRST Christopher | SEX Mor F | Mor School/Agency:\_\_\_ City LAIGO State 9/ Zip Code 3377/ Home Phone (727) 8/2-8605 Parent/Guardian Address (if different) Work Phone ( City\_\_\_\_\_\_ State\_\_\_\_ Zip Code\_\_\_\_\_\_

Emergency Contact (other than parent/guardian) Amy Kirkland Emerg. Phone (727) 723-437/ \_\_\_\_\_\_ Ins. Policy #\_\_\_\_\_ Health Insurance Company\_ Signature of parent/guardian/adult athlete completing form FOR ATHLETES WITH DOWN SYNDROME -- Persons with Down syndrome should have a lateral x-ray of the cervical spine in hyperflexion and hyperextension. The interpretation of the radiographs should include measurements of the atlanto-dens interval. Has an x-ray evaluation for atlantoaxial instability been done? ☐ Yes ☐ No ☐ Yes ☐ No If yes, was it positive for atlantoaxial instability? (positive indicates that the atlanto-dens interval is 5mm or more) IS THERE PRESENT OR A HISTORY OF (to be completed by parent/caregiver): ☐ Yes **Z** Yes Heart problems/high blood pressure Tobacco use Chest pain ☐ Yes Major surgery or serious illness ☐ Yes ☐ Yes ☐ Yes Seizures/epilepsy/fainting spells Heat stroke/exhaustion ☐ Yes ☐ Yes Diabetes Easy bleeding Head injury/history of concussion ☐ Yes Bone/joint problems ☐ Yes ☐ Yes Hearing aid/hearing problems Immunizations (shots) are up-to-date ☐ Yes ☐ Yes ☐ Yes Blindness/vision problem Sickle cell disease or trait Special Diet Needs (list below) ☐ Yes ☐ Yes Absence of one kidney or testicle Uses a wheelchair ☐ Yes Year of last tetanus shot Other problems that would interfere with participation \_\_\_\_\_ Allergy to the following (list specific): Food None Mens"

Medication Ring WORM MEns" Insect sting/bites\_ NONE\_\_\_\_ MEDICATIONS Medication Name Dosage Date Presc. Times per day Medication Name Dosage Date Presc. Times per day NONE. PHYSCIAL EXAMINATION Normal Abnormal Normal Abnormal Normal Abnormal **Blood Pressure** Vision Oral Cavity Cardiovascular system P П Pulse Extremities Hearing Respiratory system Coordination Weight Gastrointestinal system Height Reflexes Genitourinary system Cranial nerves Other: Primary MR Etiology/Category\_ I have reviewed the above health information and examined the athlete named in the application and certify that there is no medical evidence available to me which would preclude the athlete's participation in Special Olympics. Restrictions Steven L. Pashegoha, PA-C \_\_\_\_\_ Certification: DMD DO DC PA DARNP Examiner's Name: **EXAMINER'S SIGNATURE** DATE: **OPTIONAL INFORMATION** 

O Hispanic

COTT Canada Information Carida Particad Time 2004: Section 2 Athlete Information

O Native American

O Other

O Asian O African American O Caucasian

Ethnic background:

# OFFICIAL SPECIAL OLYMPICS RELEASE FORM



COUNTY:	SCH	IOOL/AGENCY:	
ATHLETE NAME Last: Dune 17-	/	First: Christopher	
DATE OF BIRTH: 08/25/ wonth day	year		
I represent and warrant that, to the best of my kr participate in Special Olympics activities. I also my (or my minor child's) application and has ce evidence which would preclude me (or my mino child) have (has) Down Syndrome, I (or my min extension, radical flexion or direct pressure on no completed the official "Special Release for Athlemy area, or I (or my minor child) have (has) had Instability. I am aware that if I choose not to concestablishes the absence of Atlanto-Axial Instabil minor child) can participate in equestrian sports, alpine skiing, squat lift and football (soccer).	represent that a lice ortified, based on an incredited, based on an incredited from participarticity (or my minor child) cannot participarticity (or my minor child a full radiological of mplete the "Special dity, I (or my minor content of gymnastics, diving,	nsed physician has reviewed the health informindependent medical examination, that there pating in Special Olympics. I understand that ticipate in sports or events which, by their nad's) neck or upper spine unless I and two physial Instability," available from the Special Obexamination which establishes the absence of Release for Athletes with Atlanto-Axial Instability) must have the radiological examination pentathlon, butterfly stroke, diving starts in second	mation contained in is no medical at if I (or my minor ture, result in hyper-ysicians have lympics Program in Atlanto-Axial bility" form which before I (or my swimming, high jum
Special Olympics has my permission, (both during in either television, radio, film, newspapers, mage communicating the purposes and activities of Sp	gazines, and other me	edia, and in any form, for the purpose of adve	ertising or
TO BE COMPLETED BY ADULT ATHLETE	<u>OR</u>	TO BE COMPLETED BY PARENT/GUARDIAN OF MINOR	ATHLETE
If, during my participation in Special Olympics should need emergency treatment, and I am not my consent or make my own arrangements for because of my injuries, I authorize Special Oly whatever measures are necessary to protect my well-being, including, if necessary, hospitalizate I am at least 18 years old and have submitted thapplication for participation in Special Olympic	t able to give that treatment empics to take health and tion. he attached cs. I have read	If a medical emergency should arise during participation in any Special Olympics active I am not personally present so as to be constablete's care, I hereby authorize Special Obehalf, to take whatever measures are necesthe athlete is provided with any emergency including hospitalization, which Special Oladvisable in order to protect the minor athlebeing.	ities, at a time when sulted regarding the lympics, on my ssary to ensure that medical treatment, ympics deems
this paper and fully understand the provisions of that I am signing. I understand that by signing saying that I agree to the provisions of this release.  Signature of Adult Athlete	this paper, I am	I am the pareut/guardian of the minor athler application. I have read and fully understar the above release, and have explained these athlete. Through my signature on this relea agreeing to the above provisions on my own behalf of the athlete named above. I hereby the athlete named above to participate in Sp	nd the provisions of provisions to the see form, I am hehalf and on the give permission for
I hereby certify that I have reviewed this release athlete whose signature appears above. I am sa on that review, that the athlete understands this agreed to its terms.	itisfied, based	games, recreation programs and physical actions are signature of Parent/Guardian	
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# APPLICATION FOR PARTICIPATION (Medical Form) (must be completed and signed by licensed examiner every 3 years)



COUNTY:	nellas			Scho	ool/Agency:_				
SSN:589	148	17733	3	T-sh	irt Size: C	Childr	ren:	OR Adult	
LAST NAME RO	inkin		_ first_火	erth			SEX Mor F		OF BIRTH
Street Number/Address 8								1010	23 173
City Semme	1	State	Lle Zip	Code_3	327	7_	Home Phone 22	77)39	2-886
Parent/Guardian 3	the ha	skin					Work Phone 2	27)54	17-77/7
Address (if different)	<del></del>	Some					EMAIL:		•
City		State		Code			7	77.77	3.000
Emergency Contact (other	_	7 /	•					•	3.5575
Health Insurance Company Signature of parent/guardia		, ,	<i></i>	Can	kn.		Ins. Policy #	04/01	70
		radiographs shound for atlantoaxial i	uld include measur instability been do	rements of ne?	the atlanto-de	ens in	iterval.		n hyperflexion
Heart problems/high Chest pain Seizures/epilepsy/fair Diabetes Hearing aid/hearing p Blindness/vision prob Absence of one kidne	blood pressure  Iting spells  problems	Yes Tob: Yes Maj: Yes Heat Yes Easy Yes Bon: Yes Sick	e completed be accouse or surgery or seriot stroke/exhaustion beding e/joint problems le cell disease or to a wheelchair	us illness	t/caregive	E A C H II	Emotional/psychiatri Asthma/breathing processed tenses/glassed Head injury/history communizations (shots Special Diet Needs (lagent)	oblems with exe es/dentures/false of concussion s) are up-to-date ist below)	ration Yes teeth Yes Yes Yes Yes Yes
Other problems that w Allergy to the following Food Medication		h participation			ct sting/bit	es			
			MEDICA	ATIONS	<b> </b>				
Medication Name	Dosage	Date Presc.	Times per day	Medicati	on Name		Dosage	Date Presc.	Times per day
1									
	Non	PI	HYSICAL EX	KAMIN	ATION =	_			
Blood Pressure Pulse Weight Height  13  14  14  14  15  16  17  18  18  18  18  18  18  18  18  18	Vision (V) Hearing Neck Skin	mai Abnormal	Oral Cavity Extremities Coordination Reflexes	Normal	Abnormal	Resp Gast Gen	N diovascular system piratory system trointestinal system itourinary system nial nerves	ormal	Abnormal
Other:									<del></del>
Primary MR Etiology/Cate I have reviewed the above to me which would preclu	e health informatio			ed in the	application	and o	certify that there is	no medical e	vidence available
Restrictions Examiner's Name:	bre Listeria	220			Certif	icatio	n: 🗆 MD 🖼 🗖		——— A □ ARNP
EXAMINER'S SIGNA							_	TE: <u> </u>	
			OPTIONAL IN	FORMAT	ION =				
Ethnic background: O A	sian O African	American O C	aucasian O	Hispanic	O Nat	ive A	merican O C	Other	

# OFFICIAL SPECIAL OLYMPICS RELEASE FORM (SPECIAL OLYMPICS FLORIDA SPORTS INFORMATION GUIDE 2007 – 2008)



	(or beath of the	i i i i i i i i i i i i i i i i i i i		.010.0 2007	2000,	Special Diympics Florida
COUNTY:	Levelles	SCHOO	L/AGENC	Y:		
ATHLETE NAME	Last: Rank	·	First:	Ke	II	
DATE OF BIRTH:	10 / 23 / month day	7 <u>3</u> year				
participate in Special Ol my (or my minor child's evidence which would p child) have (has) Down extension, radical flexion completed the official "S my area, or I (or my min Instability. I am aware t establishes the absence of	n or direct pressure on my Special Release for Athlet or child) have (has) had a hat if I choose not to com of Atlanto-Axial Instability hate in equestrian sports, g	epresent that a licensed ified, based on an inde child) from participation rehild) cannot participation (or my minor child's) es with Atlanto-Axial a full radiological examplete the "Special Rele y, I (or my minor child	I physician pendent me in Speciate in sport neck or up Instability," mination whease for Ath I) must have	has reviewed ical examination of the control of the	wed the health is mination, that the ics. I understand its which, by the unless I and two from the Specialishes the absentant Atlanto-Axial plogical examin	information contained in here is no medical at that if I (or my minor bir nature, result in hyperophysicians have a lial Olympics Program in the of Atlanto-Axial Instability" form which
in either television, radio	y permission, (both during b, film, newspapers, maga: oses and activities of Spec	zines, and other media	, and in any	form, for	r th <b>e</b> pur <b>p</b> ose of	
TO BE COMPLETE ADULT ATHLETE	E <b>D BY</b>	<u>OR</u>			LETED BY JARDIAN O	F MINOR ATHLETE
should need emergency my consent or make my because of my injuries, whatever measures are well-being, including, i I understand that it is m complete the Athlete C	tion in Special Olympics as treatment, and I am not a yown arrangements for the I authorize Special Olympicessary to protect my high necessary, hospitalization responsibility to acquire ode of Conduct form for the contract of the contract	able to give nat treatment upics to take nealth and on. e, review and	partici I am n athlete behalf the ath	pation in ot person 's care, I , to take valete is proing hospite.	any Special Oly ally present so a hereby authorize whatever measu ovided with any alization, which	arise during the minor athlete's ympics activities, at a time whereas to be consulted regarding the ze Special Olympics, on my res are necessary to ensure that we emergency medical treatment, h Special Olympics deems to eminor athlete's health and we
application for particip this paper and fully und that I am signing. I und	Id and have submitted the ation in Special Olympics derstand the provisions of derstand that by signing the provisions of this release	. I have read the release his paper, I am	comple athlete their fe	ete the At , for the sellow athle	hlete Code of C afety and health etes.	nsibility to acquire, review and Conduct form, with and for my h of both my child/guard and minor athlete named in this
• •	LAWNW lete		applica the abo athlete	ation. I have releas Throug	ave <b>re</b> ad <b>an</b> d fu e, a <b>nd hav</b> e exp h m <b>y</b> si <b>gn</b> ature	Ily understand the provisions or blained these provisions to the on this release form, I am
athlete whose signature	ave reviewed this release appears above. I am sati athlete understands this re	sfied, based	behalf the ath	of the ath	lete named abo d above to part	ns on my own behalf and on the ove. I hereby give permission faticipate in Special Olympics d physical activity programs.
Name (print):			Signati	ure of Par	ent/Guardian	Date
Relationship to athlete:			<del>-</del>			

## OFFICIAL SPECIAL OLYMPICS RELEASE FORM



	3			Florida
COUNTY:		SC	HOOL/AGENCY:	
ATHLETE NAME	Last: Dunen		First: Christopher	
DATE OF BIRTH:	OS125 167 month day year	7_		
participate in Special Olymy (or my minor child's evidence which would prochild) have (has) Down Sextension, radical flexion completed the official "Smy area, or I (or my minor linstability. I am aware the establishes the absence of minor child) can participal pine skiing, squat lift and Special Olympics has my	empics activities. I also repression application and has certified reclude me (or my minor child syndrome, I (or my minor child for direct pressure on my (or pecial Release for Athletes woor child) have (has) had a full that if I choose not to complete f Atlanto-Axial Instability, I (ate in equestrian sports, gymnard football (soccer).	sent that a lice, based on an and) from particular cannot particular my minor chaith Atlanto-Al radiological ce the "Special or my minor lastics, diving	f, I (or my minor child) am (is) physically and ensed physician has reviewed the health inform independent medical examination, that there is inpating in Special Olympics. I understand that recipate in sports or events which, by their natified's) neck or upper spine unless I and two phy exial Instability," available from the Special Olympical examination which establishes the absence of Release for Athletes with Atlanto-Axial Instability, and the radiological examination to the purpose of advented and in any form, for the number of advented in any form, for the number of advented in the radio and in any form, for the number of advented in the radio and in any form, for the number of advented in the radio and in any form, for the number of advented in the radio and in any form, for the number of advented in the radio and in any form, for the number of advented in the radio and in any form, for the number of advented in the radio and in any form, for the number of advented in the radio and in any form, for the number of advented in the radio and in any form, for the number of advented in the radio and in any form, for the number of advented in the radio and in any form, for the number of advented in the radio and in any form of the number of advented in the radio and in the radio	nation contained in s no medical if I (or my minor ure, result in hypersicians have ympics Program in Atlanto-Axial bility" form which before I (or my wimming, high jumpame, voice or words
			nedia, and in any form, for the purpose of adve	
TO BE COMPLETE ADULT ATHLETE	ED BY	<u>OR</u>	TO BE COMPLETED BY PARENT/GUARDIAN OF MINOR A	<u>ATHLETE</u>
should need emergency my consent or make my because of my injuries, whatever measures are well-being, including, it I am at least 18 years of application for participa	treatment, and I am not able to own arrangements for that treatments are special Olympics active own arrangements for that treatments are special Olympics necessary to protect my health finecessary, hospitalization.  d and have submitted the attantion in Special Olympics. I have the provisions of the second o	to give eatment to take n and ched have read	If a medical emergency should arise during participation in any Special Olympics activi I am not personally present so as to be cons athlete's care, I hereby authorize Special Olbehalf, to take whatever measures are neces the athlete is provided with any emergency including hospitalization, which Special Olyadvisable in order to protect the minor athlebeing.	ties, at a time when ulted regarding the ympics, on my sary to ensure that medical treatment, ympics deems
that I am signing. I und saying that I agree to the Signature of Adult Athle I hereby certify that I had	ive reviewed this release with	e the	I am the parent/guardian of the minor athlete application. I have read and fully understant the above release, and have explained these athlete. Through my signature on this releast agreeing to the above provisions on my own behalf of the athlete named above. I hereby the athlete named above to participate in Sp games, recreation programs and physical act	d the provisions of provisions to the se form, I am behalf and on the give permission for ecial Olympics
	appears above. I am satisfied athlete understands this releas		Signature of Parent/Guardian	Date
Name (print):				

Relationship to athlete:\_

# APPLICATION FOR PARTICIPATION (Medical Form) (must be completed and signed by licensed examiner every 3 years)



COUNTY:			_		_			
COUNTY:	1/.7	1 360	) 9	School/				
SSN: <u>0.10 -</u>	10/	<u> </u>	<del></del>	T-shirt S	Size: Cl	ildren:	OR Adul	t:
LAST NAME OCA	ICHIV		FIRST	Wistoph	21	SEX (Mor F	DATE	OF BIRTH th/day/year
Street Number/Address	00 Star	Key Rd	# 1508				08/	25 1/92
City LArgo		State_	<u>عالم کا </u>	Code 337	7/	Home Phone (	72718/	2-8605
Parent/Guardian								
Address (if different)						Work Phone_(_	)	
City		State	Zip	Code				
Emergency Contact (other	than parent/guard	an) Any	Kirkland			Emerg. Phone_(_	727172	3-4371
Health Insurance Company		,						
Signature of parent/guardi	an/adult athlete co	mpleting form						
	yes, was it positiv	e for atlantoaxial in		indicates that t		ens interval is 5mm o	or more)	
Heart problems/high		☐ Yes To	bacco use		Z Yes	Emotional/psychiate		
Chest pain			ajor surgery or serio		∃Yes ∃¥es	Asthma/breathing p Contact lenses/glass		
Caimpeac/anilones/fair	sting challe			u -		•		
Seizures/epilepsy/fair Diabetes	iting spells	-	sy bleeding	<b>{</b>	] Yes	Head injury/history	of concussion	⊔ Yes
• • •		☐ Yes Ea			∃ Yes	Head injury/history Immunizations (sho		=
Diabetes Hearing aid/hearing p Blindness/vision prot Absence of one kidne	oroblems olem y or testicle rould interfere v	☐ Yes Ea ☐ Yes Bo ☐ Yes Sio ☐ Yes Us with participatio	nsy bleeding one/joint problems ckle cell disease or t ses a wheelchair	rait (	Yes Yes Yes Yes	<i>3</i> • <i>5</i>	ts) are up-to-date (list below)	☐ Yes ☐ Yes
Diabetes Hearing aid/hearing p Blindness/vision prot Absence of one kidne Other problems that w lilergy to the following	oroblems olem y or testicle could interfere v g (list specific):	☐ Yes Ea☐ Yes Bo☐ Yes Sio☐ Yes Us	nsy bleeding one/joint problems ckle cell disease or t ess a wheelchair	rait (	Yes Yes Yes Yes	Immunizations (sho Special Diet Needs	ts) are up-to-date (list below) shot	Yes Yes
Diabetes Hearing aid/hearing p Blindness/vision prob Absence of one kidne Other problems that w Allergy to the following	oroblems olem y or testicle could interfere v g (list specific):	☐ Yes Ea☐ Yes Bo☐ Yes Sio☐ Yes Us	nsy bleeding one/joint problems ckle cell disease or t ess a wheelchair	rait [	Yes Yes Yes Yes	Immunizations (sho Special Diet Needs of Year of last tetanus	ts) are up-to-date (list below) shot	Yes Yes
Diabetes Hearing aid/hearing p Blindness/vision prob Absence of one kidne Other problems that w Allergy to the following Food Medication	oroblems olem y or testicle could interfere v g (list specific):	☐ Yes Ea☐ Yes Bo☐ Yes Sio☐ Yes Us	sy bleeding one/joint problems ckle cell disease or t ess a wheelchair	rait [	Yes Yes Yes Yes	Immunizations (sho Special Diet Needs of Year of last tetanus	ts) are up-to-date (list below) shot	Yes Yes
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Diabetes Hearing aid/hearing p Blindness/vision prot Absence of one kidne Other problems that w Illergy to the following Food Now Medication Rin Medication Name Now e	problems plem y or testicle rould interfere v g (list specific):  2 Dosage	Yes Ea Yes Bo Yes Sio Yes Us Yes Us With participatio	MEDICATimes per day	Insect s  ATIONS  Medication N  XAMINATI	Yes Yes Yes Yes ting/bites	Immunizations (sho Special Diet Needs of Year of last tetanus  Nuncleon Dosage	ts) are up-to-date (list below) shot	☐ Yes☐ Yes☐ Times per day☐
Diabetes Hearing aid/hearing p Blindness/vision prot Absence of one kidne Other problems that w Illergy to the following Food Now Medication Name Now Lood Pressure	problems plem y or testicle  rould interfere v g (list specific):  Dosage  Vision Hearing	Yes Ea  Yes Bo  Yes Sio  Yes Us  Yes Us  With participatio  Date Presc.	MEDICA Times per day  Oral Cavity Extremities	Insect s  ATIONS  Medication N  Normal Ab	Yes Yes Yes Yes Yes ON ON R	Immunizations (sho Special Diet Needs Year of last tetanus  Nunce  Dosage  Dosage	by are up-to-date (list below) shot	Times per day  Abnormal
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Diabetes Hearing aid/hearing p Blindness/vision prot Absence of one kidne other problems that w Illergy to the following Food Now Medication Name  Medication Name  Now Illerght Illerg	Dosage  Vision Hearing Neck Skin	Yes Ea  Yes Bo  Yes Sio  Yes Us  Yes Us  Yes Us  Vith participatio	MEDICA Times per day  Oral Cavity Extremities Coordination	Insect s  ATIONS  Medication N  Normal Ab	Yes Yes Yes Yes Yes Ting/bites	Immunizations (sho Special Diet Needs Year of last tetanus  Von Ve  Dosage  Dosage  ardiovascular system espiratory system espiratory system enitourinary system	by are up-to-date (list below) shot	Times per day  Abnormal
Diabetes Hearing aid/hearing p Blindness/vision prot Absence of one kidne Other problems that w Illergy to the following Food Now Medication Name Medication Name Now P Ilood Pressure Ilo	Dosage  Vision Hearing Neck Skin  Poroblems	Yes Ba Yes Ba Yes Sid Yes Us With participatio  Mensor  Date Presc.	MEDICA  Times per day  Oral Cavity Extremities Coordination Reflexes  and the athlete name occial Olympics.	Insect s  ATIONS  Medication N  Normal Ab	Yes Yes Yes Yes Yes  Yes  ON  R G G C	Immunizations (sho Special Diet Needs of Year of last tetanus  Nuncer of last tetanus  Dosage  Dosage  ardiovascular system espiratory system astrointestinal system ranial nerves	by are up-to-date (list below) shot	Times per day  Abnormal
Diabetes Hearing aid/hearing p Blindness/vision prob Absence of one kidne Other problems that w Allergy to the following Food Now Medication Name Now Weight Leight Leight Weight Leight Absence of one kidne Other problems that w Allergy to the following Medication Name Now Weight Leight Absence of one kidne Other problems that w Allergy to the following Medication Name Now Weight Leight Absence of one kidne Absence of one kidn	Dosage  Vision Hearing Neck Skin  Poroblems	Yes Ba Yes Ba Yes Sid Yes Us With participatio  Mensor  Date Presc.	MEDICA  Times per day  Oral Cavity Extremities Coordination Reflexes  and the athlete name occial Olympics.	Insect s  ATIONS  Medication N  Normal Ab	Yes Yes Yes Yes Yes  Yes  ON  R G G G C  ication an	Immunizations (sho Special Diet Needs of Year of last tetanus  Nuncertain Dosage  Dosage  Dosage  ardiovascular system astrointestinal system ranial nerves  d certify that there is	bate Presc.  Date Presc.	Abnormal  cidence available
Diabetes Hearing aid/hearing p Blindness/vision prob Absence of one kidne Other problems that w Allergy to the following Food Now Medication Name Medication Name Veight Leight Other:  Primary MR Etiology/Catchave reviewed the above one which would preclu	Dosage  Vision Hearing Neck Skin  Pegory  e health informate the athlete's part of the a	Yes Ea Yes Bo Yes Sid Yes Us With participatio  Min S  Date Presc.	MEDICATIONS OF THE STATE OF THE	Insect s  ATIONS  Medication N  Normal Ab	Yes Yes Yes Yes Yes  Yes  ON  R G G G C  ication an	Immunizations (sho Special Diet Needs of Special Diet Needs of Year of last tetanus    Voo Ve	bate Presc.  Date Presc.	Abnormal  cidence available

#### APPLICATION FOR PARTICIPATION (Medical Form)



(must be completed and signed by	licensed examiner every 3	years)		Florida
COUNTY: Tinellas	School/Agency:			
SSN: 267 167 13558	T-shirt Size: Childre	n:	OR Adult:_	ΥC
LAST NAME DUNCON FIRST W		SEX	DATE O	
Street Number/Address 600 Starkey Rol apt 19	508	M) or F	05,2	day/year 5 / 70
City Largo State F/ Zip C	Code 3377/	Home Phone ( 2	27, 588	3-4317
Parent/Guardian - Wamma Kirkband		Work Phone ( 7	27,581	1-8767
Address (if different) SAme		EMAIL:		
CityStateZip C	Code	_	17 / 5 1	C - ( -
Emergency Contact (other than parent/guardian) Dr Price		Emerg. Phone ( )	21,581	-8161
Health Insurance Company	1	Ins. Policy #		
Signature of parent/guardian/adult athlete completing form wam_	a Kullana	)		
FOR ATHLETES WITH DOWN SYNDROME — Persons with D and hyperextension. The interpretation of the radiographs should include measure Has an x-ray evaluation for atlantoaxial instability been dor If yes, was it positive for atlantoaxial instability? (positive in the context of th	ements of the atlanto-dens into ne?	erval.	·	hyperflexion
Heart problems/high blood pressure Chest pain Seizures/epilepsy/fainting spells Diabetes Hearing aid/hearing problems Blindness/vision problem Absence of one kidney or testicle  Heart problems Of the becompleted by Tobacco use Major surgery or serious Major surgery or se	☐ Yes Er  Is illness ☐ Yes As  ☐ Yes Co  ☐ Yes He  ☐ Yes Im  ait ☐ Yes Sn	notional/psychiatric thma/breathing pro- ontact lenses/glasse: ad injury/history o munizations (shots ecial Diet Needs (li- ar of last tetanus sh	oblems with exerti s/dentures/false te f concussion ) are up-to-date ist below)	on
Other problems that would interfere with participation	a shess.		101	
Allergy to the following (list specific):  Food	Insect sting/bites	0		
Medication				
MEDICA				
	Medication Name	Dosage	Date Presc.	Times per day
Opposite 500 Dre 750 Dr				
Creary 12 ad.				_
PHYSICAL EX	AMINATION -			
Blood Pressure Pulse Weight Hearing Neck Skin Reflexes	Normal Abnormal  Cardi Respi	Novascular system ratory system pintestinal system ourinary system al nerves		] ]
Other:	Ciadii	at herves		
Primary MR Etiology/Category				
I have reviewed the above health information and examined the athlete name to me which would preclude the athlete's participation in Special Olympics.	- 1	ertify that there is	no medical evid	lence available
to me which would preclude the athlete's participation in Special Olympics.  Restrictions	cons cons	Š		
to me which would preclude the athlete's participation in Special Olympics.	cons cons	. □ MD 12/50		
to me which would preclude the athlete's participation in Special Olympics.  Restrictions  Examiner's Name:	Certification	. □ MD 12/50	□ DC □ PA	

## OFFICIAL SPECIAL OLYMPICS RELEASE FORM

(SPECIAL OLYMPICS FLORIDA SPORTS INFORMATION GUIDE 2007 – 2008)



	(3.333.0002			Florida			
COUNTY: SCHOOL			OL/AGENCY:				
ATHLETE NAME	Last:		First:				
DATE OF BIRTH:	/ / month day ye	<b>8</b> r					
participate in Special Ol my (or my minor child's evidence which would p child) have (has) Down extension, radical flexio completed the official "5 my area, or I (or my min Instability. I am aware t establishes the absence of minor child) can participal pine skiing, squat lift a Special Olympics has my in either television, radio	ympics activities. I also reproper application and has certificated me (or my minor chest syndrome, I (or my minor con or direct pressure on my (of special Release for Athletes or child) have (has) had a finat if I choose not to complete Atlanto-Axial Instability, wate in equestrian sports, gyrand football (soccer).	resent that a licens ed, based on an ind ild) from participal hild) cannot partic or my minor child' with Atlanto-Axia ill radiological ex ete the "Special Re I (or my minor chi nnastics, diving, p  and anytime after), nes, and other med	(or my minor child) am (is) physically and ed physician has reviewed the health information in the period of the health information in Special Olympics. I understand that ipate in sports or events which, by their nates; neck or upper spine unless I and two physical instability," available from the Special Of amination which establishes the absence of elease for Athletes with Atlanto-Axial Instabl) must have the radiological examination entathlon, butterfly stroke, diving starts in state of the use my (or my minor child's) likeness, in it, and in any form, for the purpose of adversariation for firm to the purpose of adversariant for the purpose of adversariant fo	nation contained in is no medical t if I (or my minor ture, result in hyper-ysicians have lympics Program in Atlanto-Axial bility" form which before I (or my swimming, high jump, same, voice or words ertising or			
TO BE COMPLETE ADULT ATHLETE	-	ll Olympics and/or	applying for funds to support these purpos  TO BE COMPLETED BY  PARENT/GUARDIAN OF MI				
If, during my participal should need emergency my consent or make my because of my injuries, whatever measures are well-being, including, it is a complete the Athlete C	tion in Special Olympics act treatment, and I am not aby y own arrangements for that I authorize Special Olympinecessary to protect my heaf f necessary, hospitalization my responsibility to acquire, ode of Conduct form for the	le to give treatment cs to take lth and review and	If a medical emergency should arise participation in any Special Olympic I am not personally present so as to athlete's care, I hereby authorize Specially, to take whatever measures at the athlete is provided with any eme including hospitalization, which Specially advisable in order to protect the min being.	es activities, at a time wher be consulted regarding the ecial Olympics, on my re necessary to ensure that regency medical treatment, ecial Olympics deems			
application for particip this paper and fully und	nd my fellow athletes.  Id and have submitted the at ation in Special Olympics.  Ierstand the provisions of the lerstand that by signing this	I have read e release	I understand that it is my responsibil complete the Athlete Code of Conduathlete, for the safety and health of betheir fellow athletes.	act form, with and for my			
	e provisions of this release.	,	I am the parent/guardian of the mino application. I have read and fully ur the above release, and have explaine athlete. Through my signature on th	derstand the provisions of the detection that the detection to the detection that the detection is release form, I am			
athlete whose signature	ave reviewed this release wi appears above. I am satisfi athlete understands this rele	ied, based	agreeing to the above provisions on behalf of the athlete named above. I the athlete named above to participal games, recreation programs and phy	hereby give permission for te in Special Olympics			
Name (print):			Signature of Parent/Grandian	Date			

Relationship to athlete:\_

# SPECIAL OLYMPICS FLORIDA TEAM DIVISION CONFIRMATION FORM

County:	Team: _				Age Group:
Coach:					
This for	m is to be completed after your tea	am compete	es in a regulation	n game with another	Special Olympics team.
Teams may	advance to State level competition p	provided they	have met the fo	llowing criteria:	
1.	For a team to advance to Sectional	ls (Basketba	II) or State (Socc	er, Softball & Volleybal	l) Competitions, the Team
	must play a minimum of 4 regulation	on games, on	e of which must	be at a Sanctioned Are	a Level I ournament or a
	Sanctioned Invitational Tournamen	it. I wo game	es must be playe	d before an Area Com	
2.	At the Area level competition, team	is with correc	ct competition in	a specific division must	place first in that division to
_	advance. When there are only 2 to	ams in a div	ision, a best 2 of	3 games series must t	e played
3.	At the Area level competition, team	is without co	rrect competition	in their specific division	will be eligible to advance
	to State level competition if they ha	sempetities	at the State level	ovent	of the Director of Sports and
T1	Training, the team will have viable of these 4 games must be recorded	compeniion o	al lije Slate jevel 2 Division Confin	eveni. mation Forme" signed	by the coaches of both
ine results	by a neutral witness and submitted to	Special Oly	mnice Florida hv	the established deadli	ne Fach team (coach)
reams and t	ff on each game played. Failure to su	ibmit these f	imples i londa by ioms will disqual	ify a team from advanc	ing to State level
competition	A teams final division will be determ	nined hased	on the information	on provided on the "Tea	om Division Confirmation
Form" the I	Division Evaluation Worksheet and th	e team's div	ision at Area Tou	rnament	
The Sport	Specific Divisioning Evaluation Wo	orksheet mu	st be submitted	for each advancing t	eam by the State Games
Entry dead	line				
By signing	this form, the coach is verifying th	nat their tea	m played at the	stipulated division le	vel on the date of the
game.					
	ould use the comment line to advise	on any facto	or that affected ei	ther team's division on	that date or the
inappropriat	e placement in a division.				
Game Date	e:Location: _				
Team A		Score	Division	Coaches Signature	<del>- ya</del>
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rine	125 Nevil 101/5		<u>~</u>	SWV 1	
Team B		Score	Division	Coaches Signature	
11.8	1 116	15	1/2	1 m	-101
4119	borough littans	12	410	MOV X	rull
,					
Comments:					
			<del></del>		
Tournamen	t Director/Witness Signature	1 1-			
		<i>J</i>			
Game Date:_	Location:		<del></del>		
Team A		Score	Division	Coaches Signature	$\sim D$
	n	17:3	7	0-1-00	
LRUI	Rave		$\propto$	Soll I	VIIV
Team B	<del></del>	Score	Division	Coaches Signature	
		11	<b>~</b> ?		T
<u>Den</u>	ninde Warriors	V	3	Mark ?	)ay/wz
Comments:		•			
Comments.					O
	. 4		1		
Tournamen	t Director/Witness Signature	ry(OC	rubl		
		0			
County:	Tear	n:			Age Group:
Coach:					-
		-			

Location: _						
Score	Division	Coaches Signature				
Score	Division	Coaches Signature				
1000.0	- Division	Codones Signaturo				
		<u> </u>				
<del></del>	* * * * * * * * * * * * * * * * * * * *					
re	<del> </del>					
Game Date: Location:						
Score	Division	Coaches Signature				
Score	Division	Coaches Signature				
	<u></u>					
re						
or State level m	uset have nlav	ved a minimum of A regulation games				
		end them to the state office as part of the				
	Score  Score  Location:  Score  Score  Score  Phil MacHard 1105 Citrus Clermont, FL	Score Division  Te  Location:  Score Division  Score Division  re  or State level must have play				