Special Olympics Florida

# SOFTBALL ROSTER

| | |
|---|---|
| COUNTY: Pinellas | ESTIMATED DIVISION: 2 |
| TEAM NAME: Devil Rays | PHONE: 727 864 8976 |
| HEAD COACH: Steve Weppner | E-MAIL: weppnespGeckard.edu |
| ADDRESS: 255 6th Ave NE #1 | CITY/ZIP: St. Petersburg 33701 |

Team type: ☒ Traditional Team ☐ Unified Sports® Team ☐ Team Skills**

Age : ☐ Pee Wee (8-11 yrs) ☐ Junior (12-15 yrs) ☐ Senior (16-22 yrs) ☒ Master (23 years & older)

The age of the oldest player on the team will determine the Age Division of the Team

| | Enter "P" for Unified Sports® Partner | Athlete Names (Last Name, First Name) | DOB |
|---|---|---|---|
| 1 | | William Duncan | 5/25/1970 |
| 2 | | Chris Duncan | 8/25/1967 |
| 3 | | Richard Crompton | 7/8/1964 |
| 4 | | Keith Rankin | 10/23/1973 |
| 5 | | Steve LaBlanc | |
| 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 | 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 T: 09/21/2007 09:58:58 E:
Clinic Job ID: 406111 Internal Job ID: 297838625

# APPLICATION FOR PARTICIPATION (Medical Form)

**(must be completed and signed by licensed examiner every 3 years)**

Special Olympics Florida

**COUNTY:** _____ School/Agency: _____

SSN: 267 67 1350 9 T-shirt Size: Children: _____ OR Adult: _____

**LAST NAME** DUNCAN **FIRST** Christopher **SEX** (M) or F **DATE OF BIRTH** month/day/year 08/25/1967

Street Number/Address 600 Starkey Rd. # 1508

City Largo State FL Zip Code 33771 Home Phone (727) 812-8605

Parent/Guardian _____

Address (if different) _____ Work Phone ( ) _____

City _____ State _____ Zip Code _____

Emergency Contact (other than parent/guardian) Amy Kirkland Emerg. Phone (727) 723-4371

Health Insurance Company _____ Ins. Policy # _____

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.

☐ Yes ☐ No Has an x-ray evaluation for atlantoaxial instability been done?

☐ 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):**

| | | | | | |
|---|---|---|---|---|---|
| Heart problems/high blood pressure | ☐ Yes | Tobacco use | ☑ Yes | Emotional/psychiatric/behavioral problems | ☐ Yes |
| Chest pain | ☐ Yes | Major surgery or serious illness | ☐ Yes | Asthma/breathing problems with exertion | ☐ Yes |
| Seizures/epilepsy/fainting spells | ☐ Yes | Heat stroke/exhaustion | ☐ Yes | Contact lenses/glasses/dentures/false teeth | ☐ Yes |
| Diabetes | ☐ Yes | Easy bleeding | ☐ Yes | Head injury/history of concussion | ☐ Yes |
| Hearing aid/hearing problems | ☐ Yes | Bone/joint problems | ☐ Yes | Immunizations (shots) are up-to-date | ☐ Yes |
| Blindness/vision problem | ☐ Yes | Sickle cell disease or trait | ☐ Yes | Special Diet Needs (list below) | ☐ Yes |
| Absence of one kidney or testicle | ☐ Yes | Uses a wheelchair | ☐ Yes | Year of last tetanus shot _____ | |

Other problems that would interfere with participation _____

Allergy to the following (list specific):

Food None Insect sting/bites None

Medication "Ring Worm Meds"

## 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 131/72 | Vision | ☑ | ☐ | Oral Cavity | ☑ | ☐ | Cardiovascular system | ☑ | ☐ |
| Pulse 59 | Hearing | ☑ | ☐ | Extremities | ☑ | ☐ | Respiratory system | ☑ | ☐ |
| Weight 260 # | Neck | ☑ | ☐ | Coordination | ☑ | ☐ | Gastrointestinal system | ☑ | ☐ |
| Height 6'0" | Skin | ☑ | ☐ | 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 _____

Examiner's Name: Steven L. Pashegoha, PA-C Certification: ☐ MD ☐ DO ☐ DC ☑ PA ☐ ARNP

EXAMINER'S SIGNATURE PA 9101721 DATE: _____

## OPTIONAL INFORMATION

Ethnic background: ○ Asian ○ African American ○ Caucasian ○ Hispanic ○ Native American ○ Other _____

# OFFICIAL SPECIAL OLYMPICS RELEASE FORM

Special Olympics Florida

COUNTY:_____ SCHOOL/AGENCY:_____

ATHLETE NAME Last: Duncan First: Christopher

DATE OF BIRTH: 08 / 25 / '67
month day year

I represent and warrant that, to the best of my knowledge and belief, I (or my minor child) am (is) physically and mentally able to participate in Special Olympics activities. I also represent that a licensed physician has reviewed the health information contained in my (or my minor child's) application and has certified, based on an independent medical examination, that there is no medical evidence which would preclude me (or my minor child) from participating in Special Olympics. I understand that if I (or my minor child) have (has) Down Syndrome, I (or my minor child) cannot participate in sports or events which, by their nature, result in hyper-extension, radical flexion or direct pressure on my (or my minor child's) neck or upper spine unless I and two physicians have completed the official "Special Release for Athletes with Atlanto-Axial Instability," available from the Special Olympics Program in my area, or I (or my minor child) have (has) had a full radiological examination which establishes the absence of Atlanto-Axial Instability. I am aware that if I choose not to complete the "Special Release for Athletes with Atlanto-Axial Instability" form which establishes the absence of Atlanto-Axial Instability, I (or my minor child) must have the radiological examination before I (or my minor child) can participate in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, squat lift and football (soccer).

Special Olympics has my permission, (both during and anytime after), to use my (or my minor child's) likeness, name, voice or words in either television, radio, film, newspapers, magazines, and other media, and in any form, for the purpose of advertising or communicating the purposes and activities of Special Olympics and/or applying for funds to support these purposes and activities.

***TO BE COMPLETED BY ADULT ATHLETE***

**OR**

If, during my participation in Special Olympics activities, I should need emergency treatment, and I am not able to give my consent or make my own arrangements for that treatment because of my injuries, I authorize Special Olympics to take whatever measures are necessary to protect my health and well-being, including, if necessary, hospitalization.

I am at least 18 years old and have submitted the attached application for participation in Special Olympics. I have read this paper and fully understand the provisions of the release that I am signing. I understand that by signing this paper, I am saying that I agree to the provisions of this release.

_____ _____-07
Signature of Adult Athlete Date

I hereby certify that I have reviewed this release with the athlete whose signature appears above. I am satisfied, based on that review, that the athlete understands this release and has agreed to its terms.

Name (print):_____

Relationship to athlete:_____

***TO BE COMPLETED BY PARENT/GUARDIAN OF MINOR ATHLETE***

If a medical emergency should arise during the minor athlete's participation in any Special Olympics activities, at a time when I am not personally present so as to be consulted regarding the athlete's care, I hereby authorize Special Olympics, on my behalf, to take whatever measures are necessary to ensure that the athlete is provided with any emergency medical treatment, including hospitalization, which Special Olympics deems advisable in order to protect the minor athlete's health and well-being.

I am the parent/guardian of the minor athlete named in this application. I have read and fully understand the provisions of the above release, and have explained these provisions to the athlete. Through my signature on this release form, I am agreeing to the above provisions on my own behalf and on the behalf of the athlete named above. I hereby give permission for the athlete named above to participate in Special Olympics games, recreation programs and physical activity programs.

_____ _____
Signature of Parent/Guardian Date

# APPLICATION FOR PARTICIPATION (Medical Form)

**(must be completed and signed by licensed examiner every 3 years)**

Special Olympics Florida

COUNTY: Pinellas School/Agency:

SSN: 589 / 48 / 7733 T-shirt Size: Children: OR Adult:

LAST NAME Rankin FIRST Keith SEX (M or F) M DATE OF BIRTH month/day/year 10/23/73

Street Number/Address 8718 94th St.

City Seminole State Fla Zip Code 33777 Home Phone (727) 392-8863

Parent/Guardian Ruth Rankin Work Phone (727) 547-7717

Address (if different) Same EMAIL: —

City — State — Zip Code —

Emergency Contact (other than parent/guardian) Joyce Hebel Emerg. Phone 727) 323-5575

Health Insurance Company Medicare, Medicaid Ins. Policy # 13272140

Signature of parent/guardian/adult athlete completing form Ruth Rankin

**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.

☐ Yes ☐ No Has an x-ray evaluation for atlantoaxial instability been done?

☐ 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):

| | | | | | |
|---|---|---|---|---|---|
| Heart problems/high blood pressure | ☐ Yes | Tobacco use | ☐ Yes | Emotional/psychiatric/behavioral problems | ☐ Yes |
| Chest pain | ☐ Yes | Major surgery or serious illness | ☐ Yes | Asthma/breathing problems with exertion | ☐ Yes |
| Seizures/epilepsy/fainting spells | ☐ Yes | Heat stroke/exhaustion | ☐ Yes | Contact lenses/glasses/dentures/false teeth | ☐ Yes |
| Diabetes | ☐ Yes | Easy bleeding | ☐ Yes | Head injury/history of concussion | ☐ Yes |
| Hearing aid/hearing problems | ☐ Yes | Bone/joint problems | ☐ Yes | Immunizations (shots) are up-to-date | ☐ Yes |
| Blindness/vision problem | ☐ Yes | Sickle cell disease or trait | ☐ Yes | Special Diet Needs (list below) | ☐ Yes |
| Absence of one kidney or testicle | ☐ Yes | Uses a wheelchair | ☐ Yes | Year of last tetanus shot | |

Other problems that would interfere with participation

Allergy to the following (list specific):

Food NKDA Insect sting/bites

Medication

## MEDICATIONS

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

## PHYSICAL EXAMINATION

| | | | Normal | Abnormal | | Normal | Abnormal | | Normal | Abnormal |
|---|---|---|---|---|---|---|---|---|---|---|
| Blood Pressure | 134/66 | Vision OD 20/20 OS 20/20 OU 20/20 | ☑ | ☐ | Oral Cavity | ☑ | ☐ | Cardiovascular system | ☑ | ☐ |
| Pulse | 84 | Hearing | ☑ | ☐ | Extremities | ☑ | ☐ | Respiratory system | ☑ | ☐ |
| Weight | 511 | Neck | ☑ | ☐ | Coordination | ☑ | ☐ | Gastrointestinal system | ☑ | ☐ |
| Height | 233 | Skin | ☑ | ☐ | 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 None

Examiner's Name: [illegible] Certification: ☐ MD ☑ DO ☐ DC ☐ PA ☐ ARNP

EXAMINER'S SIGNATURE [signature] DATE: 6-16-07

## OPTIONAL INFORMATION

Ethnic background: ○ Asian ○ African American ○ Caucasian ○ Hispanic ○ Native American ○ Other

# OFFICIAL SPECIAL OLYMPICS RELEASE FORM

(SPECIAL OLYMPICS FLORIDA SPORTS INFORMATION GUIDE 2007 – 2008)

Special Olympics Florida

**COUNTY:** Pinellas **SCHOOL/AGENCY:** _____

**ATHLETE NAME** Last: Rankin First: Keith

**DATE OF BIRTH:** 10 / 23 / 73
month day year

I represent and warrant that, to the best of my knowledge and belief, I (or my minor child) am (is) physically and mentally able to participate in Special Olympics activities. I also represent that a licensed physician has reviewed the health information contained in my (or my minor child's) application and has certified, based on an independent medical examination, that there is no medical evidence which would preclude me (or my minor child) from participating in Special Olympics. I understand that if I (or my minor child) have (has) Down Syndrome, I (or my minor child) cannot participate in sports or events which, by their nature, result in hyper-extension, radical flexion or direct pressure on my (or my minor child's) neck or upper spine unless I and two physicians have completed the official "Special Release for Athletes with Atlanto-Axial Instability," available from the Special Olympics Program in my area, or I (or my minor child) have (has) had a full radiological examination which establishes the absence of Atlanto-Axial Instability. I am aware that if I choose not to complete the "Special Release for Athletes with Atlanto-Axial Instability" form which establishes the absence of Atlanto-Axial Instability, I (or my minor child) must have the radiological examination before I (or my minor child) can participate in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, squat lift and football (soccer).

Special Olympics has my permission, (both during and anytime after), to use my (or my minor child's) likeness, name, voice or words in either television, radio, film, newspapers, magazines, and other media, and in any form, for the purpose of advertising or communicating the purposes and activities of Special Olympics and/or applying for funds to support these purposes and activities.

***TO BE COMPLETED BY ADULT ATHLETE***

**OR**

If, during my participation in Special Olympics activities, I should need emergency treatment, and I am not able to give my consent or make my own arrangements for that treatment because of my injuries, I authorize Special Olympics to take whatever measures are necessary to protect my health and well-being, including, if necessary, hospitalization.

I understand that it is my responsibility to acquire, review and complete the Athlete Code of Conduct form for the safety and health of both myself and my fellow athletes.

I am at least 18 years old and have submitted the attached application for participation in Special Olympics. I have read this paper and fully understand the provisions of the release that I am signing. I understand that by signing this paper, I am saying that I agree to the provisions of this release.

Keith Rankin 9-12-07

Signature of Adult Athlete Date

I hereby certify that I have reviewed this release with the athlete whose signature appears above. I am satisfied, based on that review, that the athlete understands this release and has agreed to its terms.

Name (print): _____

Relationship to athlete: _____

***TO BE COMPLETED BY PARENT/GUARDIAN OF MINOR ATHLETE***

If a medical emergency should arise during the minor athlete's participation in any Special Olympics activities, at a time wher I am not personally present so as to be consulted regarding the athlete's care, I hereby authorize Special Olympics, on my behalf, to take whatever measures are necessary to ensure that the athlete is provided with any emergency medical treatment, including hospitalization, which Special Olympics deems advisable in order to protect the minor athlete's health and wel being.

I understand that it is my responsibility to acquire, review and complete the Athlete Code of Conduct form, with and for my athlete, for the safety and health of both my child/guard and their fellow athletes.

I am the parent/guardian of the minor athlete named in this application. I have read and fully understand the provisions of the above release, and have explained these provisions to the athlete. Through my signature on this release form, I am agreeing to the above provisions on my own behalf and on the behalf of the athlete named above. I hereby give permission fc the athlete named above to participate in Special Olympics games, recreation programs and physical activity programs.

_____ _____

Signature of Parent/Guardian Date

# OFFICIAL SPECIAL OLYMPICS RELEASE FORM

Special Olympics Florida

COUNTY: _____ SCHOOL/AGENCY: _____

ATHLETE NAME Last: Duncan First: Christopher

DATE OF BIRTH: 08 / 25 / 67
month day year

I represent and warrant that, to the best of my knowledge and belief, I (or my minor child) am (is) physically and mentally able to participate in Special Olympics activities. I also represent that a licensed physician has reviewed the health information contained in my (or my minor child's) application and has certified, based on an independent medical examination, that there is no medical evidence which would preclude me (or my minor child) from participating in Special Olympics. I understand that if I (or my minor child) have (has) Down Syndrome, I (or my minor child) cannot participate in sports or events which, by their nature, result in hyper-extension, radical flexion or direct pressure on my (or my minor child's) neck or upper spine unless I and two physicians have completed the official "Special Release for Athletes with Atlanto-Axial Instability," available from the Special Olympics Program in my area, or I (or my minor child) have (has) had a full radiological examination which establishes the absence of Atlanto-Axial Instability. I am aware that if I choose not to complete the "Special Release for Athletes with Atlanto-Axial Instability" form which establishes the absence of Atlanto-Axial Instability, I (or my minor child) must have the radiological examination before I (or my minor child) can participate in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, squat lift and football (soccer).

Special Olympics has my permission, (both during and anytime after), to use my (or my minor child's) likeness, name, voice or words in either television, radio, film, newspapers, magazines, and other media, and in any form, for the purpose of advertising or communicating the purposes and activities of Special Olympics and/or applying for funds to support these purposes and activities.

***TO BE COMPLETED BY ADULT ATHLETE***

If, during my participation in Special Olympics activities, I should need emergency treatment, and I am not able to give my consent or make my own arrangements for that treatment because of my injuries, I authorize Special Olympics to take whatever measures are necessary to protect my health and well-being, including, if necessary, hospitalization.

I am at least 18 years old and have submitted the attached application for participation in Special Olympics. I have read this paper and fully understand the provisions of the release that I am signing. I understand that by signing this paper, I am saying that I agree to the provisions of this release.

_____ _____-07
Signature of Adult Athlete Date

I hereby certify that I have reviewed this release with the athlete whose signature appears above. I am satisfied, based on that review, that the athlete understands this release and has agreed to its terms.

Name (print): _____

Relationship to athlete: _____

**OR**

***TO BE COMPLETED BY PARENT/GUARDIAN OF MINOR ATHLETE***

If a medical emergency should arise during the minor athlete's participation in any Special Olympics activities, at a time when I am not personally present so as to be consulted regarding the athlete's care, I hereby authorize Special Olympics, on my behalf, to take whatever measures are necessary to ensure that the athlete is provided with any emergency medical treatment, including hospitalization, which Special Olympics deems advisable in order to protect the minor athlete's health and well-being.

I am the parent/guardian of the minor athlete named in this application. I have read and fully understand the provisions of the above release, and have explained these provisions to the athlete. Through my signature on this release form, I am agreeing to the above provisions on my own behalf and on the behalf of the athlete named above. I hereby give permission for the athlete named above to participate in Special Olympics games, recreation programs and physical activity programs.

_____ _____
Signature of Parent/Guardian Date

# APPLICATION FOR PARTICIPATION (Medical Form)

**(must be completed and signed by licensed examiner every 3 years)**

Special Olympics Florida

**COUNTY:** _____ School/Agency: _____

SSN: 267 167 1350 T-shirt Size: Children: _____ OR Adult: _____

**LAST NAME** DUNCAN **FIRST** Christopher **SEX** (M) or F **DATE OF BIRTH** month/day/year 08/25/1980

Street Number/Address 600 Starkey Rd #1508

City Largo State FL Zip Code 33771 Home Phone (727) 512-5605

Parent/Guardian _____

Address (if different) _____ Work Phone ( )

City _____ State _____ Zip Code _____

Emergency Contact (other than parent/guardian) Amy Kirkland Emerg. Phone (727) 723-4371

Health Insurance Company _____ Ins. Policy # _____

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.

☐ Yes ☐ No Has an x-ray evaluation for atlantoaxial instability been done?

☐ 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):**

| | | | | | |
|---|---|---|---|---|---|
| Heart problems/high blood pressure | ☐ Yes | Tobacco use | ☑ Yes | Emotional/psychiatric/behavioral problems | ☐ Yes |
| Chest pain | ☐ Yes | Major surgery or serious illness | ☐ Yes | Asthma/breathing problems with exertion | ☐ Yes |
| Seizures/epilepsy/fainting spells | ☐ Yes | Heat stroke/exhaustion | ☐ Yes | Contact lenses/glasses/dentures/false teeth | ☐ Yes |
| Diabetes | ☐ Yes | Easy bleeding | ☐ Yes | Head injury/history of concussion | ☐ Yes |
| Hearing aid/hearing problems | ☐ Yes | Bone/joint problems | ☐ Yes | Immunizations (shots) are up-to-date | ☐ Yes |
| Blindness/vision problem | ☐ Yes | Sickle cell disease or trait | ☐ Yes | Special Diet Needs (list below) | ☐ Yes |
| Absence of one kidney or testicle | ☐ Yes | Uses a wheelchair | ☐ Yes | Year of last tetanus shot _____ | |

Other problems that would interfere with participation _____

Allergy to the following (list specific):

Food None Insect sting/bites None

Medication "Ring Worm Meds"

## 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 | 131/72 | Vision | ☑ | ☐ | Oral Cavity | ☑ | ☐ | Cardiovascular system | ☑ | ☐ |
| Pulse | 64 | Hearing | ☑ | ☐ | Extremities | ☑ | ☐ | Respiratory system | ☑ | ☐ |
| Weight | 216 lbs | Neck | ☑ | ☐ | Coordination | ☑ | ☐ | Gastrointestinal system | ☑ | ☐ |
| Height | 6'0" | Skin | ☑ | ☐ | 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 _____

Examiner's Name: Steven L. Pashegoha, PA-C Certification: ☐ MD ☐ DO ☐ DC ☑ PA ☐ ARNP

**EXAMINER'S SIGNATURE** PA 9[illegible] **DATE:** _____

## OPTIONAL INFORMATION

Ethnic background: ○ Asian ○ African American ○ Caucasian ○ Hispanic ○ Native American ○ Other _____

# APPLICATION FOR PARTICIPATION (Medical Form)

**(must be completed and signed by licensed examiner every 3 years)**

Special Olympics Florida

COUNTY: Pinellas School/Agency:

SSN: 267 / 67 / 3558 T-shirt Size: Children: OR Adult: YL

LAST NAME Duncan FIRST William SEX (M or F) DATE OF BIRTH month/day/year 05/25/70

Street Number/Address 600 Starkey Rd apt 1508

City Largo State FL Zip Code 33771 Home Phone (727) 588-4317

Parent/Guardian Lwamma Kirkland Work Phone (727) 581-8767

Address (if different) Same EMAIL:

City State Zip Code

Emergency Contact (other than parent/guardian) Dr Price Emerg. Phone (727) 581-8767

Health Insurance Company Ins. Policy #

Signature of parent/guardian/adult athlete completing form Lwamma Kirkland

**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.

☐ Yes ☑ No Has an x-ray evaluation for atlantoaxial instability been done?

☐ 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):

| | | | | | |
|---|---|---|---|---|---|
| Heart problems/high blood pressure | ☐ Yes | Tobacco use | ☐ Yes | Emotional/psychiatric/behavioral problems | ☐ Yes |
| Chest pain | ☑ Yes | Major surgery or serious illness | ☑ Yes | Asthma/breathing problems with exertion | ☐ Yes |
| Seizures/epilepsy/fainting spells | ☑ Yes | Heat stroke/exhaustion | ☐ Yes | Contact lenses/glasses/dentures/false teeth | ☑ Yes |
| Diabetes | ☐ Yes | Easy bleeding | ☐ Yes | Head injury/history of concussion | ☐ Yes |
| Hearing aid/hearing problems | ☑ Yes | Bone/joint problems | ☐ Yes | Immunizations (shots) are up-to-date | ☑ Yes |
| Blindness/vision problem | ☑ Yes | Sickle cell disease or trait | ☐ Yes | Special Diet Needs (list below) | ☐ Yes |
| Absence of one kidney or testicle | ☐ Yes | Uses a wheelchair | ☐ Yes | Year of last tetanus shot | 1998 |

Other problems that would interfere with participation Depakote overdosage Creston Depression

Allergy to the following (list specific):

Food NKDA Insect sting/bites ☺

Medication ☺

## MEDICATIONS

| Medication Name | Dosage | Date Presc. | Times per day | Medication Name | Dosage | Date Presc. | Times per day |
|---|---|---|---|---|---|---|---|
| Depakote | 500 Dose | 750 | QAM | | | | |
| Risperidone | 1 mg | | QHS | | | | |
| Crestor | 10 | | qd. | | | | |

## PHYSICAL EXAMINATION

| | | Normal | Abnormal | | Normal | Abnormal | | Normal | Abnormal |
|---|---|---|---|---|---|---|---|---|---|
| Blood Pressure | 124/74 | Vision | ☐ | ☑ Above | Oral Cavity | ☑ | ☐ | Cardiovascular system | ☑ | ☐ Murmur |
| Pulse | 60 | Hearing | ☐ | ☐ | Extremities | ☑ | ☐ | Respiratory system | ☑ | ☐ |
| Weight | 157 | Neck | ☑ | ☐ | Coordination | ☑ | ☐ | Gastrointestinal system | ☑ | ☐ |
| Height | 5'5" | Skin | ☑ | ☐ | 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 Contact sports until clearance.

Examiner's Name: [illegible] Certification: ☐ MD ☑ DO ☐ DC ☐ PA ☐ ARNP

EXAMINER'S SIGNATURE [signature] DATE 9-15-07

## OPTIONAL INFORMATION

Ethnic background: ○ Asian ○ African American ○ Caucasian ○ Hispanic ○ Native American ○ Other

# OFFICIAL SPECIAL OLYMPICS RELEASE FORM

(SPECIAL OLYMPICS FLORIDA SPORTS INFORMATION GUIDE 2007 – 2008)

Special Olympics Florida

**COUNTY:**_____ **SCHOOL/AGENCY:**_____

**ATHLETE NAME** Last:_____ First:_____

**DATE OF BIRTH:** ____/____/____
month day year

I represent and warrant that, to the best of my knowledge and belief, I (or my minor child) am (is) physically and mentally able to participate in Special Olympics activities. I also represent that a licensed physician has reviewed the health information contained in my (or my minor child's) application and has certified, based on an independent medical examination, that there is no medical evidence which would preclude me (or my minor child) from participating in Special Olympics. I understand that if I (or my minor child) have (has) Down Syndrome, I (or my minor child) cannot participate in sports or events which, by their nature, result in hyper-extension, radical flexion or direct pressure on my (or my minor child's) neck or upper spine unless I and two physicians have completed the official "Special Release for Athletes with Atlanto-Axial Instability," available from the Special Olympics Program in my area, or I (or my minor child) have (has) had a full radiological examination which establishes the absence of Atlanto-Axial Instability. I am aware that if I choose not to complete the "Special Release for Athletes with Atlanto-Axial Instability" form which establishes the absence of Atlanto-Axial Instability, I (or my minor child) must have the radiological examination before I (or my minor child) can participate in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, squat lift and football (soccer).

Special Olympics has my permission, (both during and anytime after), to use my (or my minor child's) likeness, name, voice or words in either television, radio, film, newspapers, magazines, and other media, and in any form, for the purpose of advertising or communicating the purposes and activities of Special Olympics and/or applying for funds to support these purposes and activities.

***TO BE COMPLETED BY ADULT ATHLETE***

**OR**

If, during my participation in Special Olympics activities, I should need emergency treatment, and I am not able to give my consent or make my own arrangements for that treatment because of my injuries, I authorize Special Olympics to take whatever measures are necessary to protect my health and well-being, including, if necessary, hospitalization.

I understand that it is my responsibility to acquire, review and complete the Athlete Code of Conduct form for the safety and health of both myself and my fellow athletes.

I am at least 18 years old and have submitted the attached application for participation in Special Olympics. I have read this paper and fully understand the provisions of the release that I am signing. I understand that by signing this paper, I am saying that I agree to the provisions of this release.

William J. Duncan 9/17/07

Signature of Adult Athlete Date

I hereby certify that I have reviewed this release with the athlete whose signature appears above. I am satisfied, based on that review, that the athlete understands this release and has agreed to its terms.

Name (print):_____

Relationship to athlete:_____

***TO BE COMPLETED BY PARENT/GUARDIAN OF MINOR ATHLETE***

If a medical emergency should arise during the minor athlete's participation in any Special Olympics activities, at a time wher I am not personally present so as to be consulted regarding the athlete's care, I hereby authorize Special Olympics, on my behalf, to take whatever measures are necessary to ensure that the athlete is provided with any emergency medical treatment, including hospitalization, which Special Olympics deems advisable in order to protect the minor athlete's health and wel being.

I understand that it is my responsibility to acquire, review and complete the Athlete Code of Conduct form, with and for my athlete, for the safety and health of both my child/guard and their fellow athletes.

I am the parent/guardian of the minor athlete named in this application. I have read and fully understand the provisions of the above release, and have explained these provisions to the athlete. Through my signature on this release form, I am agreeing to the above provisions on my own behalf and on the behalf of the athlete named above. I hereby give permission fc the athlete named above to participate in Special Olympics games, recreation programs and physical activity programs.

_____ _____

Signature of Parent/Guardian Date

**SPECIAL OLYMPICS FLORIDA**

# TEAM DIVISION CONFIRMATION FORM

**County:** _____ **Team:** _____ **Age Group:** _____

**Coach:** _____

**This form is to be completed after your team competes in a regulation game with another Special Olympics team.** Teams may advance to State level competition provided they have met the following criteria:

1. For a team to advance to Sectionals (Basketball) or State (Soccer, Softball & Volleyball) Competitions, the Team must play a minimum of 4 regulation games, one of which must be at a Sanctioned Area Level Tournament or a Sanctioned Invitational Tournament. Two games must be played before an Area Competition
2. At the Area level competition, teams with correct competition in a specific division must place first in that division to advance. When there are only 2 teams in a division, a best 2 of 3 games series must be played
3. At the Area level competition, teams without correct competition in their specific division will be eligible to advance to State level competition if they have met the criteria list in #1 and if, at the discretion of the Director of Sports and Training, the team will have viable competition at the State level event.

The results of these 4 games must be recorded on the "*Team Division Confirmation Forms*" , signed by the coaches of both teams and by a neutral witness and submitted to Special Olympics Florida by the established deadline. *Each team (coach) must sign-off on each game played.* Failure to submit these forms will disqualify a team from advancing to State level competition. A teams final division will be determined based on the information provided on the "*Team Division Confirmation Form*", the *Division Evaluation Worksheet* and the team's division at Area Tournament

**The Sport Specific *Divisioning Evaluation Worksheet* must be submitted for each advancing team by the State Games Entry deadline**

**By signing this form, the coach is verifying that their team played at the stipulated division level on the date of the game.**

Coaches should use the comment line to advise on any factor that affected either team's division on that date or the inappropriate placement in a division.

Game Date:_____ Location: _____

| Team A | Score | Division | Coaches Signature |
|---|---|---|---|
| Pinellas Devil Rays | 16 | 2 | |
| **Team B** | **Score** | **Division** | **Coaches Signature** |
| Hillsborough Titans | 15 | 2/3 | |

Comments:

Tournament Director/Witness Signature_____

Game Date:_____ Location: _____

| Team A | Score | Division | Coaches Signature |
|---|---|---|---|
| Devil Rays | 23 | 2 | |
| **Team B** | **Score** | **Division** | **Coaches Signature** |
| Seminole Warriors | 11 | 3 | Mark Jaylor |

Comments:

Tournament Director/Witness Signature Mary C Burke

**County:** _____ **Team:** _____ **Age Group:** _____

**Coach:** _____

Game Date:_____ Location: _____

| Team A | Score | Division | Coaches Signature |
|---|---|---|---|
| | | | |
| Team B | Score | Division | Coaches Signature |
| | | | |

Comments:_____

Tournament Director/Witness Signature_____

Game Date:_____ Location: _____

| Team A | Score | Division | Coaches Signature |
|---|---|---|---|
| | | | |
| Team B | Score | Division | Coaches Signature |
| | | | |

Comments:_____

Tournament Director/Witness Signature_____

All teams advancing to Sectional or State level must have played a minimum of 4 regulation games
All forms are to be given to your county coordinator who will send them to the state office as part of the entry process

Send forms to:

Phil MacHarg
1105 Citrus Tower Blvd.
Clermont, FL 34711
(fax) 352-243-9568