# SOFTBALL ROSTER

**COUNTY:** Pinellas  
**TEAM NAME:** Devil Rays  
**HEAD COACH:** Steve Weppner  
**ADDRESS:** 255 6th Ave NE #7  
**PHONE:** 727 864 8976  
**E-MAIL:** weppnrespGeckard,edu  
**CITY/ZIP:** St. Petersburg 33701  
**ESTIMATED DIVISION:** 2  
**Team type:** ✅ Traditional Team  
**Age:** 🗓 Master (23 years & older)

---

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

<table>
<thead>
<tr>
<th>Enter “P” for Unified Sports® Partner</th>
<th>Athlete Names</th>
<th>DOB</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>William Duncan</td>
<td>5/25/1970</td>
</tr>
<tr>
<td>2</td>
<td>Chris Duncan</td>
<td>8/25/1967</td>
</tr>
<tr>
<td>3</td>
<td>Richard Crampton</td>
<td>7/8/1964</td>
</tr>
<tr>
<td>4</td>
<td>Keith Rankin</td>
<td>10/23/1973</td>
</tr>
<tr>
<td>5</td>
<td>Steve LaBlance</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Richard Green</td>
<td>7/4/1970</td>
</tr>
<tr>
<td>7</td>
<td>David Parkinson</td>
<td>9/4/1977</td>
</tr>
<tr>
<td>8</td>
<td>Tommy Minnfield</td>
<td>4/6/1966</td>
</tr>
<tr>
<td>9</td>
<td>Robert Winland</td>
<td>3/12/1969</td>
</tr>
<tr>
<td>10</td>
<td>Darrell Witherspoon</td>
<td>6/19/1977</td>
</tr>
<tr>
<td>11</td>
<td>Chris Schafer</td>
<td>11/5/1985</td>
</tr>
<tr>
<td>12</td>
<td>James Stock</td>
<td>4/5/1974</td>
</tr>
<tr>
<td>13</td>
<td>Sean Curtis</td>
<td>5/9/1976</td>
</tr>
<tr>
<td>14</td>
<td>Amanda Figueres</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Stephanie Schreck</td>
<td></td>
</tr>
</tbody>
</table>

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.
C Spine

Patient: WILLIAM J. DUNCAN
EMRN: 100034

Encounter: Sep 20 2007 12:00AM

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)

COUNTY:  
SSN: 267-16-1350  
School/Agency:  
T-shirt Size:  
OR  
Adult:  
SEX  
DATE OF BIRTH  
month/day/year  
08/25/1969  
LAST NAME DUNCAN  
FIRST CHRISTOPHER  
Street Number/Address 600 Sycamore Rd. #1508  
City, LAKE STATE  
Zip Code 33771  
Home Phone (727) 812-8605  
Parent/Guardian  
Address (if different)  
City  
State  
Zip Code  
Work Phone  
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):

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
</tr>
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<tbody>
<tr>
<td>Heart problems/high blood pressure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Chest pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Seizures/epilepsy/fainting spells</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Hearing aid/hearing problems</td>
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<td></td>
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</tr>
<tr>
<td>Blindness/vision problem</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absence of one kidney or testicle</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other problems that would interfere with participation

Allergy to the following (list specific):

Food NONE Insect sting/bites NONE Medication "Regum Mels"

MEDICATIONS

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dosage</th>
<th>Date Presc.</th>
<th>Times per day</th>
<th>Medication Name</th>
<th>Dosage</th>
<th>Date Presc.</th>
<th>Times per day</th>
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</thead>
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<tr>
<td>NONE</td>
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<td></td>
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<td>NONE</td>
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PHYSICAL EXAMINATION

<table>
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<tr>
<th>Test</th>
<th>Normal</th>
<th>Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>112/70</td>
<td></td>
</tr>
<tr>
<td>Pulse</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>Weight</td>
<td>160</td>
<td></td>
</tr>
<tr>
<td>Height</td>
<td>69</td>
<td></td>
</tr>
</tbody>
</table>

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 Pashgoba, PA-C  
Certification: MD DC PA ARNP

EXAMINER’S SIGNATURE

OPTIONAL INFORMATION

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

2017 Sports Information Guide Revised June 2004; Section 2 Athlete Information
OFFICIAL SPECIAL OLYMPICS RELEASE FORM

COUNTY: ____________________________ SCHOOL/AGENCY: ____________________________
ATHLETE NAME ___________________________________________ First: ____________________________
DATE OF BIRTH: 08 25 67

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 PARENT/GUARDIAN OF MINOR 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.

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.

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: Penella  
SSN: 589-14-7733  
School/Agency:  
T-shirt Size:  
Children: OR Adult  
SEX:  
DATE OF BIRTH: 10/23/173  
Street Number/Address: 8718 94th St  
City: Second City  
State: FL  
Zip Code: 33277  
Home Phone: 227-392-8863  
Parent/Guardian: Ruth Bank  
Work Phone: 227-542-7711  
Address (if different):  
City:  
State:  
Zip Code:  
Emergency Contact (other than parent/guardian): Roger Himmel  
Health Insurance Company: medicare, medicaid  
Ins. Policy #: 13272140  
Signature of parent/guardian/adult athlete completing form: Ruth Bank

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 ☐ No  
Tobacco use ☐ Yes  
Emotional/psychiatric/behavioral problems ☐ Yes  
Asthma/breathing problems with exertion ☐ Yes  
Chest pain ☐ Yes  
Major surgery or serious illness ☐ Yes  
Contact lenses/glasses/dentures/false teeth ☐ Yes  
Seizures/epilepsy/fainting spells ☐ Yes  
Heat stroke/exhaustion ☐ Yes  
Head injury/hist of concussion ☐ Yes  
Diabetes ☐ Yes  
Easy bleeding ☐ Yes  
Immunizations (shots) are up-to-date ☐ Yes  
Hearing aid/hearing problems ☐ Yes  
Bone/joint problems ☐ Yes  
Special Diet Needs (list below) ☐ Yes  
Blindness/vision problem ☐ Yes  
Sickle cell disease or trait ☐ Yes  
Year of last tetanus shot  
Absence of one kidney or testicle ☐ Yes  
Uses a wheelchair ☐ Yes

Other problems that would interfere with participation  
Allergy to the following (list specific):  
Food: VKDA  
Medication: Insect sting/bites

MEDICATIONS

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dosage</th>
<th>Date Presc.</th>
<th>Times per day</th>
<th>Medication Name</th>
<th>Dosage</th>
<th>Date Presc.</th>
<th>Times per day</th>
</tr>
</thead>
</table>

PHYSICAL EXAMINATION

Blood Pressure | Normal | Abnormal | Normal | Abnormal | Normal | Abnormal |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulse</td>
<td>Normal</td>
<td>Abnormal</td>
<td>Normal</td>
<td>Abnormal</td>
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<td>Weight</td>
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<td>Abnormal</td>
</tr>
<tr>
<td>Height</td>
<td>Normal</td>
<td>Abnormal</td>
<td>Normal</td>
<td>Abnormal</td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
</tbody>
</table>

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:  
Certification: ☐ MD ☐ DO ☐ DC ☐ PA ☐ ARNP  
EXAMINER'S SIGNATURE:  
DATE: 11/6/07

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)

COUNTY: _______________ SCHOOL/AGENCY: ____________________

ATHLETE NAME Last: Rando 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

TO BE COMPLETED BY
PARENT/GUARDIAN OF MINOR 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 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 Rando 9-17-07
Signature of Adult Athlete

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: ____________________

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 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 for 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

COUNTY: ____________________________ SCHOOL/AGENCY: ____________________________

ATHLETE NAME: ____________________________ Last: Dwayne, First: Christopher

DATE OF BIRTH: ____________________________

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 hyperextension, 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).

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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.

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)

COUNTY: __________________________

School/Agency: __________________________

SSN: ____________

T-shirt Size: Children: ______ OR Adult: ______

LAST NAME: Duncan
FIRST NAME: Lani

SEX: M for Male, F for Female

DATE OF BIRTH: ______/_____/_____

Street Number/Address: 600 S. Dr. # 1508

City: Large State: FL Zip Code: 33771

Home Phone: (727) 512-4605

Parent/Guardian

Address (if different): __________________________

City: __________________________ State: ______ Zip Code: ______

Emergency Contact (other than parent/guardian): __________

Emerg. Phone: (727) 512-4371

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 ☐ No Tobacco use ☐ Yes

Chest pain ☐ Yes ☐ No Major surgery or serious illness ☐ Yes

Seizures/epilepsy/fainting spells ☐ Yes ☐ No Heat stroke/exhaustion ☐ Yes

Diabetes ☐ Yes ☐ No Easy bleeding ☐ Yes

Hearing aid/hearing problems ☐ Yes ☐ No Bone/joint problems ☐ Yes

Blindness/vision problem ☐ Yes ☐ No Sickle cell disease or trait ☐ Yes

Absence of one kidney or testicle ☐ Yes ☐ No Uses a wheelchair ☐ Yes

Emotional/psychiatric/behavioral problems ☐ Yes

Asthma/breathing problems with exertion ☐ Yes

Contact lenses/glasses/dentures/soft teeth ☐ Yes

Head injury/history of concussion ☐ Yes

Immunizations (shots) are up-to-date ☐ Yes

Special Diet Needs (list below) ☐ Yes

Year of last tetanus shot __________

Other problems that would interfere with participation: __________________________

Allergy to the following (list specific):

Food: ___________ Insect sting/bites: ___________

Medication: ___________

MEDICATIONS

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dosage</th>
<th>Date Presc.</th>
<th>Times per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
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<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dosage</th>
<th>Date Presc.</th>
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<tbody>
<tr>
<td></td>
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<td></td>
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</tr>
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PHYSICAL EXAMINATION

<table>
<thead>
<tr>
<th>Blood Pressure</th>
<th>Normal</th>
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</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>Oral Cavity</td>
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<td></td>
</tr>
<tr>
<td>Abnormal</td>
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<td>Cardiovascular system</td>
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<td>Abnormal</td>
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<tr>
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<tr>
<td>Abnormal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory system</td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
<tr>
<td>Normal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abnormal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal system</td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
<tr>
<td>Normal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abnormal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitourinary system</td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
<tr>
<td>Normal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abnormal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cranial nerves</td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
<tr>
<td>Normal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abnormal</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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: __________________________

Certification: ☐ MD ☐ DO ☐ DC ☐ PA ☐ ARNP

EXAMINER'S SIGNATURE: __________________________

DATE: __________________________

OPTIONAL INFORMATION

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

2017 Social Information Guide Revised June 2017: Section 2: Athlete Information
APPLICATION FOR PARTICIPATION (Medical Form)  
(must be completed and signed by licensed examiner every 3 years)

COUNTY: Pinellas  
SSN: 267-67-3558  
School/Agency:  
T-shirt Size: Children: OR Adult: YC  

LAST NAME: Duncan  
FIRST: William  
SEX: M  
DATE OF BIRTH: 05/25/90  
Street Number/Address: 600 Starkey Rd Apt 1508  
City: Largo  
State: FL  
Zip Code: 33771  
Home Phone: (727) 588-4317  
Work Phone: (727) 581-8767  
Parent/Guardian: Mammo Kirkland  
Address (if different): Same  
City:  
State:  
Zip Code:  
Emergency Contact (other than parent/guardian): Dr. Price  
Ins. Phone: (727) 581-8767  
Health Insurance Company:  

Signature of parent/guardian/adult athlete completing form: Mammo 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 ☐ No  
Tobacco use ☑ Yes ☑ No

Chest pain ☑ Yes ☑ No  
Major surgery or serious illness ☑ Yes ☑ No

Seizures/epilepsy/fainting spells ☑ Yes ☑ No  
Heat stroke/exhaustion ☑ Yes ☑ No

Diabetes ☑ Yes ☑ No  
Easy bleeding ☑ Yes ☑ No

Hearing aid/hearing problems ☑ Yes ☑ No  
Bone/joint problems ☑ Yes ☑ No

Blindness/vision problem ☑ Yes ☑ No  
Sickle cell disease or trait ☑ Yes ☑ No

Absence of one kidney or testicle ☑ Yes ☑ No  
Uses a wheelchair ☑ Yes ☑ No

Other problems that would interfere with participation:  

Allergy to the following (list specific):

Food: NKBIA  
Insect sting/bites:  
Medication:  

MEDICATIONS

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dosage</th>
<th>Date Presc.</th>
<th>Times per day</th>
<th>Medication Name</th>
<th>Dosage</th>
<th>Date Presc.</th>
<th>Times per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depakene 500 mg</td>
<td>1500</td>
<td>9/15</td>
<td>qhs</td>
<td>Depakene 500 mg</td>
<td>1500</td>
<td>9/15</td>
<td>qhs</td>
</tr>
<tr>
<td>Carbimide 1200</td>
<td>8/14</td>
<td>9/15</td>
<td>qhs</td>
<td>Carbimide 1200</td>
<td>8/14</td>
<td>9/15</td>
<td>qhs</td>
</tr>
</tbody>
</table>

PHYSICAL EXAMINATION

<table>
<thead>
<tr>
<th>Blood Pressure</th>
<th>Normal</th>
<th>Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulse</td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
<tr>
<td>Weight</td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
<tr>
<td>Height</td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
</tbody>
</table>

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:  
Certification: ☐ MD ☐ DO ☐ DC ☐ PA ☐ ARNP  
EXAMINER'S SIGNATURE  
DATE:  

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)

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

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.

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 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 for 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 team's 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.

<table>
<thead>
<tr>
<th>Team A</th>
<th>Score</th>
<th>Division</th>
<th>Coaches Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pinellas Devil Rays</td>
<td>16</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Team B</th>
<th>Score</th>
<th>Division</th>
<th>Coaches Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hillsborough Titans</td>
<td>15</td>
<td>2/3</td>
<td></td>
</tr>
</tbody>
</table>

Comments:

Tournament Director/Witness Signature: __________________

Game Date: __________________ Location: __________________

<table>
<thead>
<tr>
<th>Team A</th>
<th>Score</th>
<th>Division</th>
<th>Coaches Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Devil Rays</td>
<td>23</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Team B</th>
<th>Score</th>
<th>Division</th>
<th>Coaches Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seminole Warriors</td>
<td>11</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

Comments:

Tournament Director/Witness Signature: __________________

County: ___________________ Team: __________________________ Age Group: ______
Coach: ___________________
Game Date: ____________  Location: ________________

<table>
<thead>
<tr>
<th>Team A</th>
<th>Score</th>
<th>Division</th>
<th>Coaches Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team B</td>
<td>Score</td>
<td>Division</td>
<td>Coaches Signature</td>
</tr>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Comments: ____________________________________________________________

Tournament Director/Witness Signature __________________________________

Game Date: ____________  Location: ________________

<table>
<thead>
<tr>
<th>Team A</th>
<th>Score</th>
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<tbody>
<tr>
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</tr>
<tr>
<td>Team B</td>
<td>Score</td>
<td>Division</td>
<td>Coaches Signature</td>
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<td></td>
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</tr>
</tbody>
</table>

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

Special Olympics Florida Sports Information Guide Revised 2007 - 2008