



## **Indiana TOPSoccer**

Registration Packet



***Special Olympics***

***Indiana***

**Be a fan™**

Dear Indiana Soccer Club Member:

The following packet is the registration packet needed for your exceptional athletes in your TOPS program.

If the exceptional athlete is already a member of Special Olympics, he/she does not need to complete either of the Special Olympics forms. He/she will only need to fill out the Indiana Soccer Media Release and if he/she has Down Syndrome, the Indiana Soccer medical release for Downs.

Please have these forms filled out and make copies of each of them. Send original set of copies to:

Indiana Soccer  
Attn: Joy Carter  
5440 Herbert Lord Road  
Indianapolis, IN 46216

I will forward the Special Olympics forms to Special Olympics Indiana and retain the completed Indiana Soccer forms in a secure location at the state soccer office. Please batch and send all forms for your participants in one envelope. If you have add-ons later in the season, please send their completed forms as you receive them.

Completed forms are imperative! A completed form will insure that your players are registered and that your players are covered with medical insurance through Special Olympics.

If you have any questions about the forms, please contact me.

Joy Carter  
TOPS Staff Liaison  
Indiana Soccer  
[joy@soccerindiana.org](mailto:joy@soccerindiana.org)  
1-800-347-4972

### Indiana Soccer Media Release

Thank you for agreeing to participate in the partnership program offered by Indiana Soccer and Special Olympics of Indiana. Please fill out this form completely and give it to an Indiana Soccer staff member or fax it to 317-829-0555.

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Club Affiliation: \_\_\_\_\_

I am being recorded/photographed voluntarily at an Indiana Soccer sanctioned event. I expressly grant permission to Indiana Soccer to edit said recording(s) and photograph(s) as desired for inclusion therein.

I hereby consent to duplication and distribution of the audio, video and or photograph content in which I appear for broadcast, exhibition and other use in any manner or media world-wide in perpetuity without further permission by me. I further consent to adaptation thereof for related instructional materials, and authorize use of my name, likeness, voice and biography for informational, promotional and publicity purposes without restriction. I acknowledge that no payment will be due to me with respect to the use of adaptation of this recording in the future.

I hereby waive and release Indiana Soccer and other organizations, institutions and agencies distribution, broadcasting, or otherwise using the footage; from any and all claims whatsoever in whole or in part of the recording(s) in which I participate.

Signature: \_\_\_\_\_

Or Parent Signature for Minor: \_\_\_\_\_

Date: \_\_\_\_\_

## INDIANA SOCCER

MEDICAL RELEASE FOR DOWN SYNDROME INDIVIDUALS PARTICIPATING IN DESIGNATED SPORTS IN EVENTS FOR LOCAL, AREA AND STATE GAMES

This form must be completed and signed by the examining physician for each participant with Down Syndrome who is expecting to participate in any sports activities sponsored by Indiana Soccer.

The completed form should be submitted upon arrival at check-in before participating in their first event.

X-RAYS AND EXAM NEED ONLY BE PERFORMED ONCE (NOT ANNUALLY). PLEASE KEEP A COPY ON PERMANENT FILE.

NAME OF ATHLETE \_\_\_\_\_

AREA/COUNTY PROGRAM \_\_\_\_\_

SCHOOL/CENTER \_\_\_\_\_

### NOTE TO EXAMINING PHYSICIAN:

Medical studies have demonstrated that approximately 15% of Down Syndrome individuals have a condition of the upper spine called Atlantoaxial Dislocation (Subluxation). Indiana Soccer requires that any athletes competing in any events held by Indiana Soccer must be examined for this condition. The examination must include x-ray views of full flexion and extension of the neck.

### PHYSICIAN'S STATEMENT

On examination of cervical spine x-rays, including full flexion and full extension views, I find that the above named athlete has:

No evidence of Atlantoaxial Dislocation

Positive or equivocal evidence of Atlantoaxial Dislocation

I have reviewed the above health information and have examined the athlete named in the application, and certify that there is no medical evidence available to me that would preclude the athlete from participating in TOPSoccer.

\_\_\_\_\_  
SIGNATURE OF PHYSICIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
Print Name of Physician

\_\_\_\_\_  
Physician Address

INFORMATION SHEET

(All participants MUST complete this form & return by the first session)

**Participant Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Is your child looking forward to soccer with:

Enthusiasm       Caution       Anxiety       Acceptance

What does your child find soothing?

\_\_\_\_\_

What methods do you use for positive feedback?

\_\_\_\_\_

What are your child's social strengths and challenges?

\_\_\_\_\_

Is your child prone to "meltdowns"?

\_\_\_\_\_

What types of situations cause your child stress?

\_\_\_\_\_

Can you share successful management tools? Please list both praise and disciplinary actions?

\_\_\_\_\_

How does your child indicate that they need to use the restroom?

\_\_\_\_\_

Does your child have any fears?

\_\_\_\_\_

Do you have any comments, concerns or helpful hints?

\_\_\_\_\_

\_\_\_\_\_



## Medical Form

*Section A should be submitted every three (3) years - staple to original with doctor's signature.*

### Section A - ATHLETE HEALTH INFORMATION

County Program: \_\_\_\_\_

Athlete Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex/Gender \_\_\_\_\_ Date of Birth (month/day/year) \_\_\_\_\_

Athlete Name \_\_\_\_\_  M  F \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Work Phone \_\_\_\_\_

Address (if different than athlete) \_\_\_\_\_ Home Phone \_\_\_\_\_

Emergency Contact (if other than parent/guardian) \_\_\_\_\_ Home Phone \_\_\_\_\_

Health/Accident Company \_\_\_\_\_ Policy # \_\_\_\_\_

	YES	NO	New Problem		YES	NO
1. Heart Disease/Heart Defect/High Blood Pressure.....				13. Impaired motor ability.....		
2. Chest Pain or Fainting Spells.....				14. Uses a wheelchair.....		
3. Seizures/Epilepsy.....				15. Allergy to the following (list specific).....		
4. Diabetes.....				Medicine.....		
5. Down Syndrome.....				Foods.....		
Have cervical spine (neck bone) x-rays been done.....				Insect Sting/Bite.....		
Atlantoaxial Instability.....				16. Special Diet.....		
6. Parent/Sibling (under 40) died of heart disease.....				17. Exercise induced wheezing.....		
7. Absence of vision/blind in one eye.....				18. Tendency to bleed easily.....		
8. Absence of one kidney or testicle.....				19. Emotional/psychiatric/behavioral problems.....		
9. Concussion or serious head injury.....				20. Serious bone or joint disorder.....		
10. Major surgery or serious illness.....				21. Sickle cell trait or disease.....		
11. Heat Stroke/exhaustion.....				22. Hearing aid/hearing loss.....		
12. Other problem that would interfere with sports participation.....				23. Contact lenses/eyeglasses.....		
List: _____				24. Dentures/false teeth.....		
▶ A physical examination performed by a licensed examiner is required every 3 years for Athletes with YES in items 1-6.				25. Immunizations (shots) are up-to-date.....		
▶ An exam is required the first time NEW is checked in items 7-13.				26. Date of last tetanus shot _____ / _____ / _____		

Comments: \_\_\_\_\_

MEDICATIONS - Please print medication name, amount, date prescribed and number of times per day medication needs to be taken (attach page if needed): \_\_\_\_\_

Person completing form (normally parent/guardian or adult athlete) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

IF HISTORY SIGNED BY ATHLETE—I have reviewed the health history with the athlete whose name appears above.

Signature \_\_\_\_\_ Date \_\_\_\_\_ Relationship to Athlete (family member, coach, friend) \_\_\_\_\_

**IMPORTANT:** If there is any significant change in the athlete's health, the athlete's condition should be reviewed by a licensed examiner before further participation.

### Section B - MEDICAL CERTIFICATION A physical examination performed by a licensed examiner is required for initial participation

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

I have reviewed the above health information on and examined the athlete named in the application, and certify there is no medical evidence available to me which would preclude the athlete's participation in Special Olympics.

Restrictions: \_\_\_\_\_

EXAMINER'S SIGNATURE \_\_\_\_\_

Examiner's Name: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_



# Athlete Application for Participation - Part 1

*This is a permanent form that must be completed before an athlete participates in Special Olympics training or competition.*

Return Part 1 to: Special Olympics Indiana; 6100 W. 36th Street, Suite 270; Indianapolis, IN 46278; Fax: (317) 328-2018; Email: entries@soindiana.org  
Retain a copy for county files. Use pen and print legibly.

## Section A - ATHLETE INFORMATION

County Program Name (Required)		Area	Athlete's Social Security Number	
			<input type="checkbox"/> M	<input type="checkbox"/> F
Last Name	First Name	Phone	Gender	
Date of Birth	Age	Place of Residence: <input type="checkbox"/> Family <input type="checkbox"/> Independent <input type="checkbox"/> Residential Services (group home, supported living, etc.)		
Address (Please include name of Agency if in residential services)				
City	State	Zip Code		
Emergency Contact Name	Phone Number	Relationship		

## Section B - ELIGIBILITY STATEMENT

Persons are eligible for Special Olympics provided they are 8 years of age or older and have been identified by an agency or professional as having an intellectual disability or having a closely related developmental disability such as those who have functional limitations, both in general learning and adaptive skills such as recreation, work, independent living, self-direction, or self-care. (Note: People with functional limitations based solely on a physical, behavioral, emotional, specific learning disability, or sensory disability are not eligible.)

The applicant is eligible for Special Olympics.  Yes  No

## Section C - RELEASE STATEMENT

I, the parent and/or legal guardian of the above named applicant (hereinafter referred to as the "Entrant") or adult Entrant in Special Olympics, hereby submit this application to participate in Special Olympics.

I represent and warrant to you that the Entrant is physically and mentally able to participate in Special Olympics activities. I also represent that a licensed physician has reviewed the Entrant's health information and has certified, based on an independent medical examination, that there is no medical evidence that would preclude the Entrant from participating in Special Olympics. I understand that if the Entrant has Down Syndrome, he/she cannot participate in sports or events which by their nature result in hyperextension, radical flexion or direct pressure on the neck or upper spine, unless a full radiological examination established the absence of Atlantotoxial Instability. I am aware that the sports and events for which this radiological examination is required are equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, and soccer.

On behalf of the Entrant and myself, I acknowledge that the Entrant will be using facilities at his/her own risk, and I, on my own behalf, hereby release, discharge and indemnify Special Olympics from all liability for injury to person or damage to property of the Entrant.

In permitting the Entrant to participate, I am specifically granting my permission, [both during and anytime after], to Special Olympics to use the Entrant's likeness, name, voice and words in television, radio, film, newspapers, magazines or 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 those purposes and activities.

If a medical emergency should arise during the Entrant's participation in any Special Olympics activities, at a time when I am not able to give my consent or make my own arrangements for treatment, I hereby authorize Special Olympics, on my behalf, to take whatever measures are necessary to ensure that the Entrant receives any emergency medical treatment, including hospitalization, which Special Olympics deems advisable in order to protect the Entrant's health and well-being.

## Section D - SIGNATURES

I have read and fully understand the provisions of the release and the Code of Conduct (Part 2). I understand that by signing this application, I am saying that I agree to the provisions of this release and to observe and abide by the rules of Special Olympics Incorporated and Special Olympics Indiana.

Signature of Adult Athlete \_\_\_\_\_ Date \_\_\_\_\_

**Witness.** 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 \_\_\_\_\_

Signature of Parent/Guardian (for athletes under age 18) \_\_\_\_\_ Date \_\_\_\_\_

## Athlete Application for Participation - Part 2

Part 2 is for use by the County Program to determine appropriate placement and supervision.

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

### Section E - PARTICIPATION STATEMENT

Special Olympics is an athlete-centered movement welcoming persons with intellectual disabilities to participate in sports training and competition. By offering a wide range of programs, specialized training for volunteers, and a focus on outreach, our organization strives to ensure an appropriate opportunity for as many athletes as possible.

However, a person's participation in Special Olympics Indiana is a privilege; it is not an entitlement. Special Olympics Indiana has the right and responsibility to protect the well-being and safety of all participants: athletes, coaches, volunteers, spectators and staff. Therefore, Special Olympics Indiana reserves the right to limit or exclude an individual's participation in the program because of, but not limited to, violent, abusive or disruptive behavior.

### Section F - BACKGROUND INFORMATION

1. To best support this Athlete in an overnight environment what volunteer to athlete ratio would you suggest?

Check one:  1:1  1:2  1:3  1:4

2. What level of personal care does this Athlete require (mobility, feeding, dressing, etc.)?  None  Some  Significant

If significant, please explain: \_\_\_\_\_

3. Does the athlete have a history of violent or disruptive behavior?  Yes  No If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

4. Does the athlete have a history of criminal behavior?  Yes  No If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

### Section G - ATHLETE CODE OF CONDUCT

The Special Olympics Code of Conduct was written by athletes to establish a system that encourages all participants to adhere to the Special Olympics philosophy, operating policies, and rules.

#### A. Sportsmanship

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

#### B. Training and Competition

1. I will train regularly.
2. I will learn and follow the rules of my sport.
3. I will listen to my coaches and the officials and ask questions when I do not understand.
4. I will always try my best during training, divisioning, and competitions.
5. I will not "hold back" in preliminary competition just to get into an easier finals competition division.

#### C. Responsibility for My Actions

1. I will not make inappropriate or unwanted physical, verbal, or sexual advances on others.
2. I will not smoke in non-smoking areas.
3. I will not drink alcohol or use illegal drugs at Special Olympics events.
4. I will not take drugs for the purpose of improving my performance.
5. I will obey all laws and Special Olympics and National Federation/Governing Body rules for my sport(s).

### FOR COUNTY PROGRAM USE

This athlete is approved for:

- Full participation in all program activities
- Participation on a probationary basis for one year during which time behavior will be reviewed.
- Participation on a limited basis:
  - With one-to-one volunteer supervision provided by: \_\_\_\_\_
  - No overnight trips
  - Not allowed to participate in the following sports: \_\_\_\_\_
- Not allowed to participate in Special Olympics pending further review.

Date: \_\_\_\_\_



