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. (Please note these forms are a separate link).

Please fill out the forms and give them to the head administrator of the club you are participating in.

Special Olympics forms need to go to the Special Olympics volunteer district coordinator in your county. If you do not know who this person is, please contact me and I will try to find out who it is for you. Otherwise, please give the forms to your head administrator at your club and she will get them to me for me to distribute accordingly.

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
317-975-2007

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 the head TOPSoccer administrator at your club.

Name: _____

Address: _____ City: _____

State: ____ Zip: _____ Phone: _____

Email: _____

Club Affiliation: _____

Date of Birth: _____

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 (Guardian) Signature for Minor: _____

Date: _____

INDIANA SOCCER

MEDICAL RELEASE FOR INDIVIDUALS WITH DOWN SYNDROME 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 individuals with Down syndrome 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