



ST. MARK'S SCHOOL
SOUTHBOROUGH, MASSACHUSETTS



Where:

St. Mark's School

25 Marlboro Road
Southborough, MA 01772

When:

Saturday's from 9:45 am - 10:45 am

- September 14th
- September 21st
- September 28th
- October 5th
- October 26th
- November 9th
- November 16th

CONTACT

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Program Operations Manager
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Special Olympics Massachusetts DEVELOPMENTAL SPORTS

Developmental Sports is an extension of the Young Athletes program that focuses on a variety of sport specific skills that children can use in future team participation. Developmental Sports is for children ages 6-10 years old with and without intellectual disabilities.

We are Unified!

Children can attend this program if there is not a competitive Special Olympics team in their area.

Developmental Sports is meant to introduce children to the world of competitive sports in a gradual, fun and non-intimidating manner. The program helps prepare children for the next step in their sports participation.

Participants will not only gain knowledge of Special Olympics sports but also the "Play Unified" movement.

What sports will be covered:

Student volunteers at St. Mark's will be participating with the athletes each week and will be covering basic skills and drills in the following sports:

Week 1: Athletics (Track & Field)

Week 2: Basketball

Week 3: Poly Hockey

Week 4: Soccer

Week 5: Softball

Week 6: Volleyball

To participate, please complete the online registration form at this link: <http://www.specialolympicsma.org/StMarksYA>. A wait list for the program will be created after the first 20 sign ups.

We will also need you to also complete an athlete medical form which is included in this flyer. The medical form is due one week before the start date.

Special Olympics
Massachusetts



Special Olympics
Developmental Sports

APPLICATION FOR PARTICIPATION (MEDICAL FORM)

BASIC INFORMATION			
Check here if New Athlete <input type="checkbox"/>		Parents/Guardian – Keep a Copy of this	<u>ALL SIGNATURES ARE REQUIRED</u>
First Name	Last Name	Male <input type="checkbox"/>	Female <input type="checkbox"/>
<input style="width: 100%;" type="text"/>		<input style="width: 100%;" type="text"/>	
Race Ethnicity (Optional)		Date of Birth	
<input type="checkbox"/> Black	<input type="checkbox"/> White	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Asian/Pacific Islander
<input type="checkbox"/> American Indian	<input type="checkbox"/> Other	<input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>	
Street Address or PO Box			Apt #
<input style="width: 100%;" type="text"/>			<input style="width: 50px;" type="text"/>
City/Town		State	ZIP Code + 4
<input style="width: 100%;" type="text"/>		<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/> - <input style="width: 30px;" type="text"/>
Home Phone # or Cell # (circle one)		Email Address	
<input style="width: 20px;" type="text"/> - <input style="width: 20px;" type="text"/> - <input style="width: 20px;" type="text"/>		<input style="width: 100%;" type="text"/>	
Parent/Guardian's Name		Home Phone # or Cell # (Circle one)	
<input style="width: 100%;" type="text"/>		<input style="width: 20px;" type="text"/> - <input style="width: 20px;" type="text"/> - <input style="width: 20px;" type="text"/>	
Emergency Contact (if other than parent/guardian)		Emergency Contact Cell Phone #	
<input style="width: 100%;" type="text"/>		<input style="width: 20px;" type="text"/> - <input style="width: 20px;" type="text"/> - <input style="width: 20px;" type="text"/>	

HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER			
Health/Accident Insurance Company		Policy #	
<input style="width: 100%;" type="text"/>		<input style="width: 100%;" type="text"/>	
Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease / heart defect / high blood pressure		Allergy:	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain		General: _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures / epilepsy/ fainting spells		Medicines: _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes		Food: _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concussion or serious head injury		Insect stings/bites: _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Major surgery or serious illness		Special diet: _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heat stroke / exhaustion		Asthma	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blindness / visual problem		Emotional/psychiatric/behavioral/requires extra supervision	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact lenses / glasses		Description: _____	
<input type="checkbox"/>	<input type="checkbox"/>	Immunizations up to date	
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	
<input type="checkbox"/>	<input type="checkbox"/>	Down syndrome (see below)	
<input type="checkbox"/>	<input type="checkbox"/>	Date of most recent tetanus immunization ____/____/____	
<input type="checkbox"/>	<input type="checkbox"/>	Currently on Medication (If yes, please bring current list with you to each competition)	

PHYSICAL EXAMINATION: TO BE COMPLETED BY HEALTH CARE PROVIDER			
Primary ID Etiology/Category: (If known) _____			
I have reviewed the above health information and have performed the above examination on this athlete and certify that the athlete can participate in Special Olympics.			
RESTRICTIONS:			
EXAMINER'S SIGNATURE: _____		Exam Date ____/____/____	
<i>(no office stamps accepted without provider's signature)</i>			
Examiner's Name			
<input style="width: 100%;" type="text"/>			
Street Address or P.O.			
<input style="width: 100%;" type="text"/>			
City/Town	State	ZIP	Phone #
<input style="width: 100%;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/>	<input style="width: 30px;" type="text"/> - <input style="width: 30px;" type="text"/> - <input style="width: 30px;" type="text"/>

ATLANTO-AXIAL INSTABILITY ASSESSMENT FOR ATHLETES WITH DOWN SYNDROME	
EXAMINER'S NOTE: SOMA requires persons with Down syndrome to have a full radiological examination establishing the absence of Atlanto-axial 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.	
Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
Has an x-ray evaluation for atlanto-axial instability been done? Date of x-ray: ____/____/____	
<input type="checkbox"/>	<input type="checkbox"/>
If yes, was it positive for atlanto-axial instability? (positive indicates that the atlanto-dens interval is 5mm or more)	

Last Name, First Name:

Form Expiration Date

APPLICATION FOR PARTICIPATION (MEDICAL FORM)

ATHLETE RELEASE: TO BE COMPLETED BY ATHLETE OVER 18, OR PARENT/GUARDIAN OF MINOR ATHLETE

For Athletes over 18 years old:

I the athlete, named above, have read the Athlete Release Form (below) and fully understand the provisions of the release that I am signing. I understand that by signing this, I am saying that I agree to the provisions of the release

Signature of adult athlete (over 18): _____

Date: ____/____/____

For Parent/Guardian of 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 the release and has agreed to its terms

Print Name: _____

Relationship to athlete: _____

Date: _____

For Parent/Guardian of Athlete under 18 years old

I am the parent (guardian) of the Athlete named in this application. I have read and fully understand the provisions of the Athlete Release Form (below), 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 my permission for the Athlete named above to participate in Special Olympics games, recreation programs, and physical activity programs.

Signature of Parent/Guardian (for athlete under 18): _____

Date: ____/____/____

ATHLETE RELEASE FORM

I represent and warrant that, to the best of my knowledge and belief, I am physically and mentally able to participate in Special Olympics activities. I also represent that a licensed medical professional has reviewed the health information contained in my application and has certified, based on an independent medical examination, that there is no medical evidence that would preclude me from participating in Special Olympics. I understand that if I have Down Syndrome, I cannot participate in sports or events which, by their nature, result in hyper-extension, radical flexion or direct pressure on my 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 jurisdiction, or I have had a full radiological examination that establishes the absence of Atlanto-axial Instability (see box on page 1). 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 must have the radiological examination before I can participate in equestrian sports, gymnastics, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, and football (soccer).

Special Olympics has my permission forever to use my likeness, name, voice or words in either television, radio, film, newspapers, magazines, and other media, and in any form, for the purpose of publicizing, promoting or communicating the purposes and activities of Special Olympics and/or applying for funds to support these purposes and activities.

I understand that by signing below I consent to participate in the Special Olympics Healthy Athletes Program, which provides individual screening assessments of health status and health care needs in the areas of: vision; oral health; hearing; physical therapy; and a variety of health promotion areas (height, weight, sun protection, etc.). I understand that information gathered as part of the Healthy Athletes Program screening process may be used in group form (anonymously) to assess and communicate the overall health needs of athletes and to develop programs to address those needs. I understand there is no obligation for me to participate in the Healthy Athletes Program and that I may decide not to participate. Provision of these health services is not intended as a substitute for regular care. I also understand that I should seek my own independent medical advice and assistance irrespective of the provisions of these services and that Special Olympics is not through the provision of these provisions responsible for my health.

I acknowledge that Special Olympics events may involve overnight activities and that the housing arrangements for each event may differ. I understand that I should contact the Special Olympics Program in my jurisdiction if I have any questions about housing arrangements for a specific event or the housing policy in general.

If, during my participation in Special Olympics activities, I should need emergency medical treatment, and I am not able to give my consent or make my own arrangements for that treatment for any reason, I authorize Special Olympics to take whatever measures it deems necessary to protect my health and well-being, including, if necessary, hospitalization. **(IF YOU HAVE RELIGIOUS OBJECTIONS TO RECEIVING SUCH MEDICAL TREATMENT, PLEASE CROSS OUT THIS PARAGRAPH, INITIAL IT AND SIGN AND ATTACH THE SPECIAL PROVISIONS REGARDING MEDICAL TREATMENT FORM)**