

# ATHLETE REGISTRATION FORM

Special Olympics



State Special Olympics Program: \_\_\_\_\_

Are you a new athlete to Special Olympics or Re-Registering? New Athlete Re-Registering

| <b>ATHLETE INFORMATION</b>   |   |                      |
|--|---|----------------------|
| <b>First Name:</b>   | <b>Middle Name:</b>                               |                      |
| <b>Last Name:</b>  | <b>Preferred Name:</b>                            |                      |
| <b>Date of Birth (mm/dd/yyyy):</b>   | Female  | Male                 |
| <b>Race/Ethnicity (Optional):</b>  |   |                      |
| American Indian/Alaskan Native   | Asian   | Two or More Races    |
| Black or African American  | Native Hawaiian or Other Pacific Islander         |                      |
| White  | Hispanic or Latino (specific origin group: _____) |                      |
| <b>Language(s) Spoken in Athlete's Home (Optional):</b> Check all that apply   |   |                      |
| English  | Spanish   | Other (please list): |
| <b>Street Address:</b>   |   |                      |
| <b>City:</b>   | <b>State:</b>                                     | <b>Postal Code:</b>  |
| <b>Phone:</b>  | <b>E-mail:</b>                                    |                      |
| <b>Sports/Activities:</b>  |   |                      |
| <b>Athlete Employer, if any (Optional):</b>  |   |                      |
| <b>Does the athlete have the capacity to consent to medical treatment on his or her own behalf?</b> <span style="float: right;">Yes    No</span> |   |                      |
| <b>PARENT / GUARDIAN INFORMATION (required if minor or otherwise has a legal guardian)</b>   |   |                      |
| <b>Name:</b>   |   |                      |
| <b>Relationship:</b>   |   |                      |
| Same Contact Info as Athlete   |   |                      |
| <b>Street Address:</b>   |   |                      |
| <b>City:</b>   | <b>State:</b>                                     | <b>Postal Code:</b>  |
| <b>Phone:</b>  | <b>E-mail:</b>                                    |                      |
| <b>EMERGENCY CONTACT INFORMATION</b>   |   |                      |
| Same as Parent/Guardian  |   |                      |
| <b>Name:</b>   |   |                      |
| <b>Phone:</b>  | <b>Relationship:</b>                              |                      |
| <b>PHYSICIAN &amp; INSURANCE INFORMATION</b>   |   |                      |
| <b>Physician Name:</b>   |   |                      |
| <b>Physician Phone:</b>  |   |                      |
| <b>Insurance Company:</b>  | <b>Insurance Policy Number:</b>                   |                      |
| <b>Insurance Group Number:</b>   |   |                      |

# Athlete Medical Form – HEALTH HISTORY

(To be completed by the athlete or parent/guardian/caregiver and brought to exam)

**Special  
Olympics**



Athlete First & Last Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Athlete Date of Birth (mm/dd/yyyy): \_\_\_\_\_ Female Male

STATE PROGRAM: \_\_\_\_\_ E-mail: \_\_\_\_\_

**ASSOCIATED CONDITIONS - Does the athlete have (check any that apply):**

|                                       |                        |                    |
|---------------------------------------|------------------------|--------------------|
| Autism                                | Down Syndrome          | Fragile X Syndrome |
| Cerebral Palsy                        | Fetal Alcohol Syndrome |                    |
| Other Syndrome, please specify: _____ |                        |                    |

**ALLERGIES & DIETARY RESTRICTIONS**

No Known Allergies  
 Latex  
 Medications: \_\_\_\_\_  
 Insect Bites or Stings: \_\_\_\_\_  
 Food: \_\_\_\_\_

**ASSISTIVE DEVICES - Does the athlete use (check any that apply):**

|                       |                    |                      |
|-----------------------|--------------------|----------------------|
| Brace                 | Colostomy          | Communication Device |
| C-PAP Machine         | Crutches or Walker | Dentures             |
| Glasses or Contacts   | G-Tube or J-Tube   | Hearing Aid          |
| Implanted Device      | Inhaler            | Pacemaker            |
| Removable Prosthetics | Splint             | Wheel Chair          |

List any special dietary needs: \_\_\_\_\_

**SPORTS PARTICIPATION**

List all Special Olympics sports the athlete wishes to play: \_\_\_\_\_

Has a doctor ever limited the athlete's participation in sports?

No Yes *If yes, please describe:* \_\_\_\_\_

**SURGERIES, INFECTIONS, VACCINES**

List all past surgeries: \_\_\_\_\_

Does the athlete currently have any chronic or acute infection?

No Yes *If yes, please describe:* \_\_\_\_\_

Has the athlete ever had an abnormal Electrocardiogram (EKG) or Echocardiogram (Echo)? *If yes, describe date and results*

Yes, had abnormal EKG  
 Yes, had abnormal Echo

Has the athlete had a Tetanus vaccine in the past 7 years? No Yes

**EPILEPSY AND/OR SEIZURE HISTORY**

Epilepsy or any type of seizure disorder No Yes

*If yes, list seizure type:* \_\_\_\_\_

*If yes, had seizure during the past year?* No Yes

**MENTAL HEALTH**

|  |    |     |                        |    |     |
|--|----|-----|------------------------|----|-----|
| Self-injurious behavior during the past year | No | Yes | Depression (diagnosed) | No | Yes |
| Aggressive behavior during the past year     | No | Yes | Anxiety (diagnosed)    | No | Yes |

Describe any additional mental health concerns: \_\_\_\_\_

**FAMILY HISTORY**

Has any relative died of a heart problem before age 50? No Yes

Has any family member or relative died while exercising? No Yes

List all medical conditions that run in the athlete's family: \_\_\_\_\_

# Athlete Medical Form – HEALTH HISTORY

(To be completed by the athlete or parent/guardian/caregiver and brought to Exam)



Athlete's First and Last Name: \_\_\_\_\_

**HAS THE ATHLETE EVER BEEN DIAGNOSED WITH OR EXPERIENCED ANY OF THE FOLLOWING CONDITIONS**

|  |    |     |  |    |     |                    |    |     |
|--|----|-----|--|----|-----|--------------------|----|-----|
| Loss of Consciousness                        | No | Yes | High Blood Pressure  | No | Yes | Stroke/TIA         | No | Yes |
| Dizziness during or after exercise           | No | Yes | High Cholesterol   | No | Yes | Concussions        | No | Yes |
| Headache during or after exercise            | No | Yes | Vision Impairment  | No | Yes | Asthma             | No | Yes |
| Chest pain during or after exercise          | No | Yes | Hearing Impairment   | No | Yes | Diabetes           | No | Yes |
| Shortness of breath during or after exercise | No | Yes | Enlarged Spleen  | No | Yes | Hepatitis          | No | Yes |
| Irregular, racing or skipped heart beats     | No | Yes | Single Kidney  | No | Yes | Urinary Discomfort | No | Yes |
| Congenital Heart Defect                      | No | Yes | Osteoporosis   | No | Yes | Spina Bifida       | No | Yes |
| Heart Attack                                 | No | Yes | Osteopenia   | No | Yes | Arthritis          | No | Yes |
| Cardiomyopathy                               | No | Yes | Sickle Cell Disease  | No | Yes | Heat Illness       | No | Yes |
| Heart Valve Disease                          | No | Yes | Sickle Cell Trait  | No | Yes | Broken Bones       | No | Yes |
| Heart Murmur                                 | No | Yes | Easy Bleeding  | No | Yes | Dislocated Joints  | No | Yes |
| Endocarditis                                 | No | Yes | If female athlete, list date of last menstrual period: _____ |    |     |                    |    |     |

**Describe any past broken bones or dislocated joints**

(if yes is checked for either of those fields above):

**List any other ongoing or past medical conditions:**

**Neurological Symptoms for Spinal Cord Compression and Atlanto-axial Instability**

|   |    |     |  |    |     |
|---|----|-----|--|----|-----|
| <b>Difficulty controlling bowels or bladder</b>   | No | Yes | <i>If yes, is this new or worse in the past 3 years?</i> | No | Yes |
| <b>Numbness or tingling in legs, arms, hands or feet</b>  | No | Yes | <i>If yes, is this new or worse in the past 3 years?</i> | No | Yes |
| <b>Weakness in legs, arms, hands or feet</b>  | No | Yes | <i>If yes, is this new or worse in the past 3 years?</i> | No | Yes |
| <b>Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet</b> | No | Yes | <i>If yes, is this new or worse in the past 3 years?</i> | No | Yes |
| <b>Head Tilt</b>  | No | Yes | <i>If yes, is this new or worse in the past 3 years?</i> | No | Yes |
| <b>Spasticity</b>   | No | Yes | <i>If yes, is this new or worse in the past 3 years?</i> | No | Yes |
| <b>Paralysis</b>  | No | Yes | <i>If yes, is this new or worse in the past 3 years?</i> | No | Yes |

**PLEASE LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW**

(includes inhalers, birth control or hormone therapy)

| Medication, Vitamin or Supplement Name | Dosage | Times per Day | Medication, Vitamin or Supplement Name | Dosage | Times per Day | Medication, Vitamin or Supplement Name | Dosage | Times per Day |
|--|--------|---------------|--|--------|---------------|--|--------|---------------|
|  |        |               |  |        |               |  |        |               |
|  |        |               |  |        |               |  |        |               |
|  |        |               |  |        |               |  |        |               |
|  |        |               |  |        |               |  |        |               |
|  |        |               |  |        |               |  |        |               |

Is the athlete able to administer his or her own medications?    No    Yes

**Name of Person Completing this Form    Relationship to Athlete    Phone    Email**

# Athlete Medical Form – PHYSICAL EXAM

(To be completed by a Licensed Medical Professional qualified to conduct exams & prescribe medications)



Athlete's First and Last Name: \_\_\_\_\_

## MEDICAL PHYSICAL INFORMATION

(To be completed by a Licensed Medical Professional qualified to conduct physical exams and prescribe medications)

| Height                     | Weight   | BMI (optional) | Temperature    | Pulse | O <sub>2</sub> Sat | Blood Pressure (in mmHg)     |          | Vision                          |               |     |     |  |  |
|----------------------------|----------|----------------|----------------|-------|--------------------|------------------------------|----------|---------------------------------|---------------|-----|-----|--|--|
| cm                         | kg       | BMI            | C              |       |                    | BP Right:                    | BP Left: | Right Vision<br>20/40 or better | No            | Yes | N/A |  |  |
| in                         | lbs      | Body Fat %     | F              |       |                    |                              |          | Left Vision<br>20/40 or better  | No            | Yes | N/A |  |  |
| Right Hearing (Finger Rub) | Responds | No Response    | Can't Evaluate |       |                    | Bowel Sounds                 | Yes      | No                              |               |     |     |  |  |
| Left Hearing (Finger Rub)  | Responds | No Response    | Can't Evaluate |       |                    | Hepatomegaly                 | No       | Yes                             |               |     |     |  |  |
| Right Ear Canal            | Clear    | Cerumen        | Foreign Body   |       |                    | Splenomegaly                 | No       | Yes                             |               |     |     |  |  |
| Left Ear Canal             | Clear    | Cerumen        | Foreign Body   |       |                    | Abdominal Tenderness         | No       | RUQ                             | RLQ           | LUQ | LLQ |  |  |
| Right Tympanic Membrane    | Clear    | Perforation    | Infection      | NA    |                    | Kidney Tenderness            | No       | Right                           | Left          |     |     |  |  |
| Left Tympanic Membrane     | Clear    | Perforation    | Infection      | NA    |                    | Right upper extremity reflex | Normal   | Diminished                      | Hyperreflexia |     |     |  |  |
| Oral Hygiene               | Good     | Fair           | Poor           |       |                    | Left upper extremity reflex  | Normal   | Diminished                      | Hyperreflexia |     |     |  |  |
| Thyroid Enlargement        | No       | Yes            |                |       |                    | Right lower extremity reflex | Normal   | Diminished                      | Hyperreflexia |     |     |  |  |
| Lymph Node Enlargement     | No       | Yes            |                |       |                    | Left lower extremity reflex  | Normal   | Diminished                      | Hyperreflexia |     |     |  |  |
| Heart Murmur (supine)      | No       | 1/6 or 2/6     | 3/6 or greater |       |                    | Abnormal Gait                | No       | Yes, describe below             |               |     |     |  |  |
| Heart Murmur (upright)     | No       | 1/6 or 2/6     | 3/6 or greater |       |                    | Spasticity                   | No       | Yes, describe below             |               |     |     |  |  |
| Heart Rhythm               | Regular  | Irregular      |                |       |                    | Tremor                       | No       | Yes, describe below             |               |     |     |  |  |
| Lungs                      | Clear    | Not clear      |                |       |                    | Neck & Back Mobility         | Full     | Not full, describe below        |               |     |     |  |  |
| Right Leg Edema            | No       | 1+ 2+ 3+ 4+    |                |       |                    | Upper Extremity Mobility     | Full     | Not full, describe below        |               |     |     |  |  |
| Left Leg Edema             | No       | 1+ 2+ 3+ 4+    |                |       |                    | Lower Extremity Mobility     | Full     | Not full, describe below        |               |     |     |  |  |
| Radial Pulse Symmetry      | Yes      | R>L            | L>R            |       |                    | Upper Extremity Strength     | Full     | Not full, describe below        |               |     |     |  |  |
| Cyanosis                   | No       | Yes, describe  |                |       |                    | Lower Extremity Strength     | Full     | Not full, describe below        |               |     |     |  |  |
| Clubbing                   | No       | Yes, describe  |                |       |                    | Loss of Sensitivity          | No       | Yes, describe below             |               |     |     |  |  |

### SPINAL CORD COMPRESSION & ATLANTO-AXIAL INSTABILITY (AAI) (Select one)

Athlete shows **NO EVIDENCE** of neurological symptoms or physical findings associated with spinal cord compression or atlanto-axial instability. **OR**

Athlete has neurological symptoms or physical findings that could be associated with spinal cord compression or atlanto-axial instability and **must receive an additional neurological evaluation** to rule out additional risk of spinal cord injury prior to clearance for sports participation.

### ATHLETE CLEARANCE TO PARTICIPATE (TO BE COMPLETED BY EXAMINER ONLY)

Licensed Medical Examiners: It is recommended that the examiner review items on the medical history with the athlete or their guardian, prior to performing the physical exam. If an athlete needs further medical evaluation please make a referral below and second physician for referral should complete page 4.

This athlete is **ABLE** to participate in Special Olympics sports without restrictions.

This athlete is **ABLE** to participate in Special Olympics sports **WITH** restrictions. Describe → \_\_\_\_\_

This athlete **MAY NOT participate** in Special Olympics sports at this time & **MUST** be further evaluated by a physician for the following concerns:

- |                              |                                  |   |
|------------------------------|----------------------------------|---|
| Concerning Cardiac Exam      | Acute Infection                  | O <sub>2</sub> Saturation Less than 90% on Room Air |
| Concerning Neurological Exam | Stage II Hypertension or Greater | Hepatomegaly or Splenomegaly                        |
| Other, please describe:      |                                  |   |

### Additional Licensed Examiner's Notes and Recommended (but not required) Follow-up:

- |                                    |                                     |  |
|------------------------------------|-------------------------------------|--|
| Follow up with a cardiologist      | Follow up with a neurologist        | Follow up with a primary care physician      |
| Follow up with a vision specialist | Follow up with a hearing specialist | Follow up with a dentist or dental hygienist |
| Follow up with a podiatrist        | Follow up with a physical therapist | Follow up with a nutritionist                |

Other/Exam Notes:

|  |  |           |            |
|--|--|-----------|------------|
| Signature of Licensed Medical Examiner |  | Exam Date | Name:      |
|  |  |           | E-mail:    |
|  |  |           | Phone:     |
|  |  |           | License #: |

# Athlete Medical Form – MEDICAL REFERRAL FORM

(To be completed by a Licensed Medical Professional only if referral is needed)



Athlete's First and Last Name: \_\_\_\_\_

**This page only needs to be completed and signed if the physician on page three does not clear the athlete and indicates further evaluation is required.**

**Athlete should bring the previously completed pages to the appointment with the specialist.**

Examiner's Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

I have been asked to perform an additional athlete exam for the following medical concern(s) - *Please describe:*

Concerning Cardiac Exam      Acute Infection      O<sub>2</sub> Saturation Less than 90% on Room Air

Concerning Neurological Exam      Stage II Hypertension or Greater      Hepatomegaly or Splenomegaly

Other, please describe:

**In my professional opinion, this athlete MAY now participate in Special Olympics sports (indicate restrictions or limitations below):**

**Yes**

**Yes, but with restrictions (*list below*)**

**No**

Additional Examiner Notes/Restrictions:

Examiner E-mail: \_\_\_\_\_

Examiner Phone: \_\_\_\_\_

License: \_\_\_\_\_

**Examiner's Signature**

**Date**

**This section to be completed by Special Olympics staff only, if applicable.**

This medical exam was completed at a MedFest event?      Yes      No

The athlete is a Unified Partner or a Young Athlete Participant?      Unified Partner      Young Athlete

# ATHLETE RELEASE FORM

Special Olympics



I agree to the following:

1. **Ability to Participate.** I am physically able to take part in Special Olympics activities.
2. **Likeness Release.** I give permission to Special Olympics, Inc., Special Olympics games organizing committees, and Special Olympics accredited Programs (collectively "Special Olympics") to use my likeness, photo, video, name, voice, and words to promote Special Olympics and raise funds for Special Olympics.
3. **Risk of Concussion and Other Injury.** I know there is a risk of injury. I understand the risk of continuing to play sports with or after a concussion or other injury. I may have to get medical care if I have a suspected concussion or other injury. I also may have to wait 7 days or more and get permission from a doctor before I start playing sports again.
4. **Emergency Care.** If I am unable, or my guardian is unavailable, to consent or make medical decisions in an emergency, I authorize Special Olympics to seek medical care on my behalf, unless I mark one of these boxes:
  - I have a religious or other objection to receiving medical treatment. (Not common.)
  - I do not consent to blood transfusions. (Not common.)
 (If either box is marked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)
5. **Overnight Stay.** For some events, I may stay in a hotel or someone's home. If I have questions, I will ask.
6. **Health Programs.** If I take part in a health program, I consent to health activities, screenings, and treatment. This should not replace regular health care. I can say no to treatment or anything else at any time.
7. **Personal Information.** I understand that Special Olympics will be collecting my personal information as part of my participation, including my name, image, address, telephone number, health information, and other personally identifying and health related information I provide to Special Olympics ("personal information").
  - I agree and consent to Special Olympics:
    - using my personal information in order to: make sure I am eligible and can participate safely; run trainings and events; share competition results (including on the Web and in news media); provide health treatment if I participate in a health program; analyze data for the purposes of improving programming and identifying and responding to the needs of Special Olympics participants; perform computer operations, quality assurance, testing, and other related activities; and provide event-related services.
    - using my personal information and creating a profile of me for communications and marketing purposes, including direct digital marketing through email, SMS, social media, and other channels.
    - sharing my personal information with (i) researchers, business partners, public health agencies, and other organizations that are studying intellectual disabilities and the impact of Special Olympics activities, (ii) medical professionals in an emergency, and (iii) government authorities for the purpose of assisting me with any visas required for international travel to Special Olympics events and for any other purpose necessary to protect public safety, respond to government requests, and report information as required by law.
  - I understand Special Olympics is a global organization with headquarters in the United States of America. I acknowledge that my personal information may be stored and processed in countries outside my country of residence, including the United States. Such countries may not have the same level of personal data protection as my country of residence, and I agree that the laws of the United States will govern your processing of my personal information as provided in this consent.
  - I have the right to ask to see my personal information or to be informed about the personal information that is processed about me. I have the right to ask to correct and delete my personal information, and to restrict the processing of my personal information if it is inconsistent with this consent.
  - *Sharing of Personal Information.* Personal information may be shared consistent with this form and as further explained in the Special Olympics privacy policy at [www.SpecialOlympics.org/Privacy\\_Policy.aspx](http://www.SpecialOlympics.org/Privacy_Policy.aspx).

|   |                      |
|---|----------------------|
| <b>Athlete Name:</b>  | <b>E-mail:</b>       |
| <b>ATHLETE SIGNATURE</b> (required for adult athlete with capacity to sign legal documents)   |                      |
| I have read and understand this form. If I have questions, I will ask. By signing, I agree to this form.  |                      |
| <b>Athlete Signature:</b>   | <b>Date:</b>         |
| <b>PARENT/GUARDIAN SIGNATURE</b> (required for athlete who is a minor or lacks capacity to sign legal documents)  |                      |
| I am a parent or guardian of the athlete. I have read and understand this form and have explained the contents to the athlete as appropriate. By signing, I agree to this form on my own behalf and on behalf of the athlete. |                      |
| <b>Parent/Guardian Signature:</b>   | <b>Date:</b>         |
| <b>Printed Name:</b>  | <b>Relationship:</b> |



## CODE OF CONDUCT ATHLETE

Special Olympics is committed to the highest ideals of sport and expects all athletes to honor sport and Special Olympics and are required to abide by the following Code of Conduct:

### **Respect for Others**

- I will practice good sportsmanship.
- I will act in ways that bring respect to me, my coaches, my team and Special Olympics.
- I will be safe and courteous to others.

### **Positive Training and Competition Behaviors**

- I will regularly attend training for my sport.
- I will be on time for any training or competition.
- I will learn and follow the rules of my sport.
- I will listen and follow the instructions of my coaches and the officials and ask questions when I do not understand.
- I will always try my best during training and at competitions.
- I will not "hold back" in preliminary competition just to get into an easier final competition division.
- I will fully participate as a member of my Team including traveling and staying with overnight with my Team.

### **Taking Responsibility For My Actions**

- I will obey all laws and Special Olympics rules
- I will only smoke in designated areas and not while participating in a Special Olympics training or competition.
- I will not drink alcohol or use illegal drugs at Special Olympics events.
- I will not use bad language or insult other athletes, coaches, volunteers or staff.
- I will not fight with other athletes, coaches, volunteers or staff.
- I will not make inappropriate or unwanted sexual advances to others.
- I will follow the Special Olympics policy that says athletes cannot date volunteers.

I understand that if I do not obey this Code of Conduct, I will be subject to a range of consequences by Special Olympics up to and including not being allowed to participate.

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Print Name of Athlete or Parent/Guardian Date

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Signature of Athlete or Parent/Guardian Date

**WAIVER AND RELEASE OF LIABILITY, ASSUMPTION OF RISK AND INDEMNIFICATION  
AGREEMENT FOR COMMUNICABLE DISEASES  
("Agreement") for  
SPECIAL OLYMPICS**

In consideration of being allowed to participate in any way in Special Olympics sports training, competition or fundraising activities, the undersigned acknowledges, appreciates, and agrees that:

1. Participation includes possible exposure to and illness from infectious and/or communicable diseases including but not limited to MRSA, influenza, and COVID-19. While particular rules and personal discipline may reduce this risk, the risk of serious illness and death does exist; and,
2. I KNOWINGLY AND FREELY ASSUME ALL SUCH RISKS, both known and unknown, EVEN IF ARISING FROM THE NEGLIGENCE OF THE RELEASEES or others, and assume full responsibility for my participation; and,
3. I willingly agree to comply with the stated and customary terms and conditions for participation as regards protection against infectious diseases. If, however, I observe and any unusual or significant hazard during my presence or participation, I will remove myself from participation and bring such to the attention of the nearest official immediately; and,
4. I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, HEREBY RELEASE AND HOLD HARMLESS Special Olympics, Inc, Special Olympics Southern California their officers, officials, agents, and/or employees, other participants, sponsoring agencies, sponsors, advertisers, and if applicable, owners and lessors of premises used to conduct the event ("RELEASEES"), WITH RESPECT TO ANY AND ALL ILLNESS, DISABILITY, DEATH, or loss or damage to person or property, WHETHER ARISING FROM THE NEGLIGENCE OF RELEASEES OR OTHERWISE, to the fullest extent permitted by law.

**I HAVE READ THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IF FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.**

Name of Participant: \_\_\_\_\_

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

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

**FOR PARTICIPANTS OF MINORITY AGE (UNDER AGE 18 AT THE TIME OF REGISTRATION)**

This is to certify that I, as parent/guardian, with legal responsibility for this participant, have read and explained the provisions in this waiver/release to my child/ward including the risks of presence and participation and his/her personal responsibilities for adhering to the rules and regulations for protection against communicable diseases. Furthermore, my child/ward understands and accepts these risks and responsibilities. I for myself, my spouse, and child/ward do consent and agree to his/her release provided above for all the Releasees and myself, my spouse, and child/ward do release and agree to indemnify and hold harmless the Releasees for any and all liabilities incident to my minor child's/ward's presence or participation in these activities as provided above, EVEN IF ARISING FROM THEIR NEGLIGENCE, to the fullest extent provided by law.

Name of parent/guardian: \_\_\_\_\_

Parent guardian/signature: \_\_\_\_\_

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