

SPECIAL OLYMPICS KANSAS
MEDICAL ADDENDUM FOR DOWN SYNDROME INDIVIDUALS

This form must be completed and signed by the examining physician for each individual with Down syndrome who desires to participate in any Special Olympics event or competition. Upon completion, please mail this form (which is signed by the attending physician) to: Special Olympics Kansas, 5280 Foxridge Drive, Mission, Kansas 66202.

Part I.

Name of Athlete _____ Social Security Number _____

Sex _____ Age _____ Birthdate (Mo./Day/Yr.) _____

School/Organization _____ City _____

Name of Coach _____ Phone () _____

Part II.

Note to Examining Physician:

Studies have shown that approximately 10% of persons with Down syndrome have the condition of Atlantoaxial Subluxation. Special Olympics Kansas requires cervical spine x-rays including full flexion and full extension views in order to confirm the existence of the Atlantoaxial condition.

Part III.

Physician Statement:

One examination of cervical spine x-rays including full flexion and full extension views, I find that the above named athlete has: (check one)

____ **Negative** or no evidence of Atlantoaxial Subluxation (Proceed to Part V unless as a result of another medical condition the athlete should not participate in an activity.)

____ **Positive** or equivocal evidence of Atlantoaxial Subluxation requires signature of examining physician and family physician. (Proceed to Part IV and check all activities in which the individual may participate on a year-round basis.)

I have notified the parent/guardian of the nature and extent of the condition.

Yes ____ No ____ Not applicable ____

Part IV.

- | | | | |
|-------------------------|---------------------------|---------------------------|---------------------|
| ____ ALPINE SKIING* | ATHLETICS (Track & Field) | ____ BOCCE | ____ POWERLIFTING |
| | ____ Running Event | ____ BOWLING | ____ ROLLER SKATING |
| AQUATICS | ____ Race Walking | ____ CHEERLEADING | ____ SNOWSHOEING |
| ____ All Diving Starts* | ____ Running Long Jump | ____ CYCLING | ____ SOCCER* |
| ____ Breaststroke | ____ Standing Long Jump | ____ EQUESTRIAN SPORTS* | ____ Ind. |
| Skills | | | |
| ____ Backstroke | ____ High Jump* | ____ FIGURE SKATING | ____ SOFTBALL |
| ____ Butterfly* | ____ Shot Put | ____ FLOOR HOCKEY | ____ Ind. Skills |
| ____ Freestyle | ____ Softball Throw | ____ GOLF | ____ SPEED SKATING |
| ____ One-Meter Dive* | ____ Pentathlon* | GYMNASTICS | ____ TEAM HANDBALL |
| ____ Springboard Dive* | ____ BASKETBALL | ____ Artistic Gymnastics* | ____ TENNIS |
| | ____ Ind. Skills | ____ Rhythmic Gymnastics* | ____ VOLLEYBALL |
| | | ____ NORDIC SKIING | ____ Ind. Skills |

*High Risk Sports – very dangerous for positive Atlantoaxial Subluxation.

If athlete is **Positive**, check all the activities in which the individual may participate on a year-round basis.

Part V.

Signature of Examining Physician

Name of Physician (Please Print)

Date

Address/City

Signature of Family Physician

Name of Family Physician (Please Print)

Date

Address/City