Special Olympics New Zealand Medical Certificate

This medical certificate must be completed and signed by a physician who is registered with the Medical Council of New Zealand. The athlete and/or their parent/caregiver must sign the release at the bottom of page 2, to allow Special Olympics New Zealand to seek emergency medical assistance if required.

Notes for Physicians

Special Olympics is an organised programme of year round sports training and competition for children and adults who have an intellectual disability/developmental delay.

An individual is eligible for Special Olympics if:

- An agency or professional has identified them as having an intellectual disability **OR**
- There is a cognitive delay determined through nationally recognised standardised tests **OR**
- There is a developmental disability affecting general learning and adaptive skills in at least two of the following areas:
  - communication
  - self-care
  - daily living
  - social skills
  - health & safety
  - functional academics
  - work capabilities
  - leisure

An individual is not eligible to participate in Special Olympics if:

- Their disability is solely due to physical disability, emotional disturbances, behaviour disorders, specific learning disabilities e.g. dyslexia, psychiatric illness or sensory disabilities. Athletes with autism must also have an intellectual disability to be eligible.

The programme caters for a diverse range of abilities and levels of fitness, in 13 different sports. The programmes are mostly organised and run by volunteer coaches.

All participants in Special Olympics activities are required to undergo a medical screening on joining the programme and to renew the medical certificate every four years (sooner if there are illness/injury concerns). This is a mandatory requirement in accordance with Special Olympics New Zealand's Accreditation Licence to operate, issued by Special Olympics International. The local Special Olympics New Zealand Club committee holds the original medical certificate; and all coaches who are involved with the coaching of that athlete hold a copy. Special Olympics New Zealand's National Office will hold a record of all medical certificate dates and doctor contact details. Medical certificates are required at all training sessions and are to be carried whenever the athlete travels away to a competition event in case treatment is needed for illness or injury.

Where an athlete has an existing medical condition or other health concerns a recommendation on the level of participation or any restrictions/precautions needed would be appreciated.

If the individual has their National Health Index number this is particularly helpful for emergency situations away from home where a medical practitioner who does not know an athlete needs to identify any significant medical history and the athlete cannot communicate the information.

Individuals with Down syndrome must have an x-ray screening for Atlanto-axial Sublaxation (Instability), before participating in sports or events, involving hyperextension, radical flexion or direct pressure on the neck or upper spine. If the result is positive then **Section 3: Special Release for Athletes with Atlanto-axial Instability** must be completed and signed by a physician and should include any restrictions if applicable. Restricted sports and events include: equestrian sports, gymnastics, dive starts, individual medley events and butterfly stroke in swimming, high jump, Alpine skiing, snowboarding, squat lift, football, plus any warm up exercise placing undue pressure on the head and neck. The screening only needs to be done once.

In addition to this medical certificate a medication update is provided by family/caregivers/advocates when travelling away to sports events.

Form M1 - Athlete Medical Certificate *(Please note that ALL questions must be answered)*

Section 1 – *(To be completed by parent / caregiver)*

1.1 Athlete Information

Surname: _____ ___ First Name: _____ Gender (M/F): _____

Club: _____ Date of Birth: _____ Ethnicity:_____

Address: _____ Suburb/City: _____

Post Code: _____ Email:_____ Home phone no. _____

Mobile no. _____ Name of Residential Service Provider if applicable: _____

Please tick the sports you are currently involved in or intend to be involved in:

Alpine skiing	☐	Bowling (tenpin)	☐	Powerlifting	☐		
Aquatics	☐	Equestrian	☐	Snowboarding	☐		
Athletics	☐	Football	☐	Table Tennis	☐		
Basketball	☐	Golf	☐				
Bocce	☐	Indoor bowls	☐				

1.2 Emergency Contact Information

Surname: _____ First Name: _____ Gender (M/F): _____

Relationship to Athlete: _____Phone no. _____

Address: _____

City: _____ Email: _____

1.3 Useful Information

Yes	No	If Yes is ticked, please identify by circling option	Yes	No	
☐	☐	Uses a wheelchair	☐	☐	Wears dentures/plates
☐	☐	Has other mobility issues	☐	☐	Has hearing loss / hearing aid
☐	☐	Wears contact lenses / glasses	☐	☐	Requires a special diet

Any specific support issues stemming from personal, health or disability status

_____

_____

Any religious or customary issues requiring support_____

_____

1.4 Authorisation for emergency medical assistance

I_____ hereby authorise Special Olympics New Zealand to seek emergency medical
(*Name of parent, caregiver or guardian)*

assistance for _____ in the event of illness or injury.
. *(Name of athlete)*

Signature of parent/caregiver/guardian _____ Date _____

Special Olympics New Zealand

Section 2 – *(To be completed by a Registered Medical Practitioner)*

Athlete Name: _____ **NHI Number:** _____

2.1 Physical Examination *(Please indicate if the athlete has any concerns or disorders in the following areas, further information can be provided if necessary in the space provided)*

Primary diagnosis for qualification for Special Olympics involvement_____

Blood pressure ____/____ **Weight (kilograms):** _____ **Height (centimetres):** _____

Yes	No	If Yes is ticked, please identify by circling option
		Heart Disease/heart defect/high blood pressure
		Seizures / epilepsy / fainting spells
		Diabetes
		Concussion or serious head injury
		Bone or joint problem
		Blood disorder
		Asthma
		Immunisations up to date, including tetanus
		Neck
		Extremities

Yes	No	
		Allergy:
		Medicines _____
		Food _____
		Insect stings/bites _____
		Other _____
		Gastrointestinal system
		Genitourinary system
		Skin
		Nervous system
		Respiratory system

Further details_____

_____

_____

Date of most recent tetanus immunisation: ____/____/____ **Hepatitis B Status** (please circle): immune / carrier / unknown

2.2 Medications

Medication name	Dosage	Date prescribed	Times per day

Any medication side- effects to be aware of/avoid?_____

What might be expected if person becomes unwell? _____

2.3 Does this athlete have Down syndrome? **Yes** / **No** (circle). If **yes**, you must complete the box below:

Atlanto-axial Instability Assessment for Athletes with Down syndrome

***Examiners Note**: If the Athlete has Down syndrome, Special Olympics New Zealand requires 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. The sports and events for which such a radiological examination are required are: equestrian sports, gymnastics, dive starts, individual medley events and butterfly stroke in swimming, high jump, Alpine skiing, snowboarding, squat lift, football plus any warm up exercise placing undue pressure on the head and neck.*

Yes	No	
		Has an x-ray evaluation for Atlanto-axial instability been done?
		If yes, was it positive for Atlanto-axial instability? (Positive indicates that the Atlanto-dens interval is 5mm or more)

If YES, Section 3 must be completed before the athlete can train or compete in any of the sports or activities highlighted above.

Athlete Name: _____

I have read the attached information and reviewed the above health information and have performed the above examination on this Athlete within the past six months and certify that the Athlete meets the eligibility criteria for participation in Special Olympics activities.

Any restrictions recommended for their participation: _____

_____

Physician's Signature: _____ Date: _____

Physician's Name (Please PRINT):_____

Address : _____

_____ Phone: _____

Physician's stamp: **REQUIRED**

Section 3 – *ONLY NEEDS TO BE COMPLETED FOR ATHLETES DIAGNOSED WITH ATLANTO-AXIAL INSTABILITY (To be completed by a Registered Medical Practitioner, Adult Athlete and Family)*

Athlete Name: _____

Certification by Physician

I have examined the Athlete named in the attached application, who has Down syndrome and who has been diagnosed as having Atlanto-axial Instability. I certify based on my review of their health information, that despite the diagnosis of Atlanto-axial Instability, this Athlete is not medically precluded from participation in Special Olympics events. I further certify that I have explained to the Athlete named in this application, (and to the parent or guardian whose signature appears below, if the Athlete is a minor), the medical risks associated with Atlanto-axial Instability and in particular, the risks associated with the Athlete's participation in sports or events which, by their nature, may result in hyper-extension, radical flexion or direct pressure on the neck or upper spine. These sports and events include the risks from participating in equestrian sports, gymnastics, dive starts, individual medley events and butterfly stroke in swimming, high jump, Alpine skiing, snowboarding, squat lift, football plus any warm up exercise placing undue pressure on the head and neck.

Any restrictions recommended for their participation:

_____

Physician's Signature: _____ Date: _____

Physician's Name (Please PRINT):_____

Address : _____

_____ Phone: _____

Certification of Adult Athlete *(Required for adult Athletes (18 years and over) with diagnosis of Atlanto-axial Instability)*

I am the Athlete named in this application. I certify that:

1. I have been informed by the physician named above that I have Atlanto-axial Instability.

2. The risks associated with that condition, including the risks from participating in equestrian sports, gymnastics, dive starts, individual medley events and butterfly stroke in swimming, high jump, Alpine skiing, snowboarding, squat lift, football plus any warm up exercise placing undue pressure on the head and neck have been fully explained to me by the physician named above, and I fully understand the possible medical consequences if I participate in any of these sports or events.

3. Although I recognise and understand the risks and possible medical consequences, I certify that I am taking these risks knowingly and voluntarily, of my own free will, because of my desire to participate in Special Olympics, including any or all of the sports listed above, based on the certification of the physician named above that I am not medically precluded from participating in the Special Olympics events outlined in (2) above.

Name: _____

Address: _____

_____ Phone: _____

Signature of Adult Athlete _____ Date_____

Signature of Partner, or Parent _____ Date_____

Athlete Name: _____

Certification of Parent / Guardian *(Required for MINOR Athletes (under 18 years) with diagnosis of Atlanto-axial Instability)*

I am the parent/guardian of the Athlete named in this application. I certify that:

1. I have been informed by the physician named above that the Athlete in my care has Atlanto-axial Instability.

2. The risks associated with that condition, including the risks from participating in equestrian sports, gymnastics, dive starts, individual medley events and butterfly stroke in swimming, high jump, Alpine skiing, snowboarding, squat lift, football plus any warm up exercise placing undue pressure on the head and neck have been fully explained to me by the physician named above, and I fully understand the possible medical consequences of the Athlete in my care participating in any of these sports or events.

3. Although I recognise and understand the risks and possible medical consequences, I hereby give my permission for the athlete in my care to participate in Special Olympics, including any or all of the sports or events listed above, based on the certification of the physician named above that the athlete in my care is not medically precluded from participating in the Special Olympics events outlined in (2) above.

   Athlete Name: _____

   Address: _____

   _____ Phone: _____

   Signature of Parent/Guardian_____ Date: _____