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 1.

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*

AQUATICS

____All Diving Starts*

____Breaststroke

____Backstroke

____Butterfly*

____Freestyle

____One-Meter Dive*

____Springboard Dive*

ATHLETICS (Track & Field)

____Running Event

____Race Walking

____Running Long Jump

____Standing Long Jump

____High Jump*

____Shot Put

____Softball Throw

____Pentathlon*

____BASKETBALL

____Ind. Skills

____BOCCE

____BOWLING

____CHEERLEADING

____CYCLING

____EQUESTRIAN SPORTS*

____FIGURE SKATING

____FLOOR HOCKEY

____GOLF

GYMNASTICS

____Artistic Gymnastics*

____Rhythmic Gymnastics*

____NORDIC SKIING

____POWERLIFTING

____ROLLER SKATING

____SNOWSHOEING

____SOCCER*

____Ind. Skills

____SOFTBALL

____Ind. Skills

____SPEED SKATING

____TEAM HANDBALL

____TENNIS

____VOLLEYBALL

____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