

Team Name:					Re	gion:		
Unified Partner Informat	tion							
Last Name:	First:	Middl	e:		Sex: 🗆	Male 🗅 Female	Birth date	:_//
Address:								
City:						P Code:		
Phone No.: ()								
Name of Parent or Guard	ian:				Ph	one No.: _())	
Address:								
City:		State:			ZIF	P Code:		
Emergency Information								
Person to be contacted in								
Address:					Ph	one No.: _())	
Health and Accident Ins								
Company Name:					Po	licy No.:		
Health Information								
History of: Yes No Bleed	ing Problems			Bone C)r loint	Problems		
□ Yes □ No Hearin		Yes	🗆 No	Vision I	Probler	ns		
□ Yes □ No Head						es/Glasses		
□ Yes □ No Faintii □ Yes □ No Heart			□ No □ No	Hearing		pairment		
□ Yes □ No Heat I	llness or Cold Injury	Yes	🗆 No	Requiri	ng Spe	cial Equipment		
□ Yes □ No Hernia								
□ Yes □ No Recer □ Yes □ No Fema			□ No □ No		Diet in	leeds		
□ Yes □ No Pregn				0 11 01				
Medications/Immunizati	ons							
Medication Name		Amount		Time		Date Prescri	ibed	
Allergies to Medication:	Yes 🗅 No	Describe:						
Tetanus: 🗆 Yes 🗅 No							ot:/	/
I, am at least 18 years old. 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.								
Special Olympics has my permission to use my likeness, name, voice, or words in either television, radio, film, newspapers, magazines, and other medias, and in any form, for the purpose of advertising or communicating the purposes and activities of Special Olympics and/or applying for funds to support those purposes and activities.								
If during my participation in special Olympics activities, I should need emergency medical treatment, and am not able to give my consent or make								
my own arrangements for that treatment because of my injuries. I authorize Special Olympics to take whatever measures are necessary to insure that I receive the emergency medical treatment which Special Olympics deems necessary to protect my health and well-being, including if necessary,								
hospitalization.	y medical treatment which S	pecial Olympics deem	s necessa	ry to prote	ect my he	ealth and well-being, i	including if n	ecessary,
I, the undersigned have red and fully understand the provisions of the above release and herby agree that I will be bound thereby and shall defend you and hold you harmless of and disaffirmation.								
						Date:		
Signature of Adult Unified Partner:Date:								
have explained them to that person. I herby agree that I and said person will be bound thereby and shall defend you and hold you harmless for any disaffirmation thereof by said person.								
I hereby give my permission for to participate in Special Olympics games, recreation programs, and physical activity programs.								ı
Signature of Parent/Guardian for Unified Partner under18:				Date:				