

Special Release for Athletes with Atlantoaxial Instability

Certification by Physicians

We have examined the athlete named in the application, who has Down syndrome and who has been diagnosed as having Atlantoaxial Instability. We certify, based on our examinations of the athlete and our review of the health information contained in this application, that despite the diagnosis of Atlantoaxial Instability, this athlete is not medically precluded from participation in Special Olympics. We further certify that we 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 Atlantoaxial 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 (signatures of two physicians required).

Physician #1	Physician #2
Restrictions (if any)	Restrictions (if any)
Physician's Name	Physician's Name
Address	Address
Phone	Phone
Signature of Physician	Signature of Physician
Date	Date

Certification of Adult Athlete

(Required for adult athletes with diagnosis of Atlantoaxial Instability)

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

1. I have been informed by the physicians named above that I have Atlantoaxial Instability.
2. The risks associated with that condition, including the risks from participating in equestrian, gymnastics, judo, pentathlon, butterfly stroke, diving starts in aquatics, high jump, alpine skiing, and soccer have been fully explained to me by the physicians listed above, and I fully understand the possible medical consequences if I participate in any of these sports or events.
3. Although I recognize 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 certifications of the two physicians named above that I am not medically precluded from participating in Special Olympics.

Athlete Name	Last	First	MI
Address			
Phone			
Signature of Adult Athlete		Date	
Signature of Parent/Guardian/Next of Kin		Date	

(continued on the following page)

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Certification of Parent/Guardian/Next of Kin

(Required for minor athletes with diagnosis of Atlantoaxial Instability)

I am the parent/guardian/next of kin of the athlete named in this application. I certify that:

1. I have been informed by the physicians named that the athlete has Atlantoaxial Instability.
2. The risks associated with that condition, including the risks from participating in sports have been fully explained to me by the physicians listed, and I fully understand the possible medical consequences of the athlete participating in any of these sports or events.
3. Although I recognize and understand the risks and possible medical consequences, I hereby give permission for the athlete to participate in Special Olympics, including any or all of the sports listed, based on the certifications of the two physicians named that the athlete is not medically precluded from participating in Special Olympics.

Athlete Name	Last	First	MI
Address			
Phone			
Signature of Parent/Guardian/Next of Kin			Date