Athlete Medical Form – **HEALTH HISTORY**

(To be completed by the athlete or parent/guardian/caregiver and brought to exam)

Special Olympics Illinois

Medical Form Valid for 3 years from date of medical professional's signature

Region _____ **Primary Agency Name**_____ **Secondary Agency Name** _____

Name of person completing form:_____ **Relationship to Athlete** _____

Phone____-____-_____ **Email Address** _____ **Date Completed** _____

If individual is a new athlete or has a change in their guardianship status then a Special Olympics Illinois Consent Form must be submitted with the Medical Form.

ATHLETE INFORMATION

Athlete Last Name:_____ **Athlete First Name:**_____

Preferred Name: _____ **Athlete Date of Birth** (mm/dd/yyyy): _____

Athlete Gender Identity: ☐ **Female** ☐ **Male** ☐ **Other**

Athlete Ethnicity/Race:

- ☐ **Asian**
- ☐ **American Indian/Alaskan Native**
- ☐ **Black/African American**
- ☐ **Hispanic/Latino**
- ☐ **Native Hawaiian/Other Pacific Islander**
- ☐ **White**
- ☐ **Two or More Races**
- ☐ **Other**
- ☐ **Prefer Not to Answer**

If a new athlete, has athlete ever been convicted or charged with a criminal offense other than minor traffic violations? ☐ **No** ☐ **Yes**

If a currently registered athlete, in the past 3 years has athlete been convicted or charged with a criminal offense other than minor traffic violations? ☐ **No** ☐ **Yes** *If the answer to either question is Yes, Special Olympics Illinois may require additional information from the athlete or responsible parent/guardian.*

Athlete Mailing Address: Street _____ **City:** _____ **State:** _____ **Zip:** _____

Athlete Email Address: _____ **Athlete Phone Number:** _____-_____-_____

Athlete Employer (if applicable): _____

Name of Athlete's Primary Physician / Health Provider: _____

PARENT / GUARDIAN INFORMATION

Athlete ☐ **is or is** ☐ **not their own guardian (Please mark appropriate box)**

The following information is for the ☐ **Parent or** ☐ **Guardian of the athlete listed above.**

Last Name:_____ **First Name:** _____

Mailing Address (if different than athlete's):

Street: _____ **City:** _____ **State:** _____ **Zip:** _____

Email Address: _____ **Phone Contact Number:** _____-_____-_____

EMERGENCY CONTACT INFORMATION (Must list at least one emergency contact)

Emergency Contact Person #1: Name _____ **Phone:** _____-_____-_____

Emergency Contact Person #2: Name _____ **Phone:** _____-_____-_____

Athlete Medical Form – **HEALTH HISTORY**

(To be completed by the athlete or parent/guardian/caregiver and brought to exam)

Special Olympics Illinois

Athlete's First and Last Name: _____

DIAGNOSED SYNDROMES *(check all that apply)*

☐ Autism ☐ Down Syndrome ☐ Fragile X Syndrome ☐ Cerebral Palsy ☐ Fetal Alcohol Syndrome ☐ Other: _____

HEART HEALTH & HISTORY *(check all that apply)*

Congenital Heart Defect	☐ No	☐ Yes	☐ Treated in past 12 months	Heart Murmur	☐ No	☐ Yes	☐ Treated in past 12 months
Heart Attack	☐ No	☐ Yes	☐ Treated in past 12 months	Heart Illness	☐ No	☐ Yes	☐ Treated in past 12 months
High Blood Pressure	☐ No	☐ Yes	☐ Treated in past 12 months	Chest pain during or after exercise	☐ No	☐ Yes	☐ Treated in past 12 months
Cardiomyopathy	☐ No	☐ Yes	☐ Treated in past 12 months	Ever had abnormal EKG	☐ No	☐ Yes	☐ Treated in past 12 months
Pacemaker	☐ No	☐ Yes	☐ Treated in past 12 months	Ever had abnormal Echo	☐ No	☐ Yes	☐ Treated in past 12 months
Heart Valve Disease	☐ No	☐ Yes	☐ Treated in past 12 months	Other: _____	☐ No	☐ Yes	☐ Treated in past 12 months

HEAD INJURY HISTORY *(check all that apply)*

Concussion(s) ☐ No ☐ Yes ☐ Treated in past 12 months

Traumatic Brian Injury (TBI) ☐ No ☐ Yes ☐ Treated in past 12 months Other: _____ ☐ No ☐ Yes ☐ Treated in past 12 months

VISION AND/OR HEARING ISSUES *(check all that apply)*

☐ Legally Blind ☐ Deaf ☐ Glasses or Contacts

☐ Vision Impaired ☐ Hearing Impaired ☐ Hearing Aids

ALLERGIES & DIETARY RESTRICTIONS *(check all that apply & explain when indicated)*

☐ Latex ☐ Insect Bites or Stings: _____

☐ Food: _____ ☐ Medications: _____ Other: _____

PULMONARY HEALTH & HISTORY *(check all that apply)*

Asthma	☐ No	☐ Yes	☐ Treated in past 12 months	Sleep Apnea (C-PAP Machine)	☐ No	☐ Yes	☐ Treated in past 12 months
COPD	☐ No	☐ Yes	☐ Treated in past 12 months	Other: _____	☐ No	☐ Yes	☐ Treated in past 12 months
Uses an Inhaler	☐ No	☐ Yes	☐ Treated in past 12 months				

MENTAL HEALTH *(check all that apply)*

Self-injurious behavior during the past year ☐ No ☐ Yes Anxiety (diagnosed) ☐ No ☐ Yes Depression (diagnosed) ☐ No ☐ Yes

Aggressive behavior during the past year ☐ No ☐ Yes Describe any additional mental health concerns: _____

OTHER MEDICAL CONDITIONS *(check all that apply)*

Stroke/TIA	☐ No	☐ Yes	☐ Treated in past 12 months	Arthritis	☐ No	☐ Yes	☐ Treated in past 12 months
Diabetes	☐ No	☐ Yes	☐ Treated in past 12 months	Dislocated Joints	☐ No	☐ Yes	☐ Treated in past 12 months
Heat Exhaustion	☐ No	☐ Yes	☐ Treated in past 12 months	Syncope	☐ No	☐ Yes	☐ Treated in past 12 months
Heat Stroke	☐ No	☐ Yes	☐ Treated in past 12 months	Hepatitis	☐ No	☐ Yes	☐ Treated in past 12 months
Colostomy	☐ No	☐ Yes	☐ Treated in past 12 months	Sickle Cell Trait/Disease	☐ No	☐ Yes	☐ Treated in past 12 months
G-Tube or J-Tube	☐ No	☐ Yes	☐ Treated in past 12 months	Seizure Disorder	☐ No	☐ Yes	☐ Treated in past 12 months
Epilepsy	☐ No	☐ Yes	☐ Treated in past 12 months	Other: _____	☐ No	☐ Yes	☐ Treated in past 12 months

Has athlete had a Tetanus vaccine in past 7 years? ☐ No ☐ Yes Date of Shot _____

Is athlete pregnant? ☐ No ☐ Yes Expected Due Date _____ Month _____ Year

NEUROLOGICAL SYMPTOMS FOR SPINAL CORD COMPRESSION & ATLANTO-AXIAL INSTABILITY *(check all that apply)*

Difficulty controlling bowels or bladder	☐ No	☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No	☐ Yes
Numbness or tingling in legs, arms, hands or feet	☐ No	☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No	☐ Yes
Weakness in legs, arms, hands or feet	☐ No	☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No	☐ Yes
Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet	☐ No	☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No	☐ Yes
Head Tilt	☐ No	☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No	☐ Yes
Spasticity	☐ No	☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No	☐ Yes
Paralysis	☐ No	☐ Yes	*If yes, is this new or worse in the past 3 years?*	☐ No	☐ Yes

LIST ANY MEDICATION, VITAMINS OR DIETARY/HERBAL/NUTRITIONAL SUPPLEMENTS (includes inhalers, birth control, hormone therapy)

Medication/Vitamin/Supplement Name: _____ Dosage: _____ Times Per Day: _____

Medication/Vitamin/Supplement Name: _____ Dosage: _____ Times Per Day: _____

Medication/Vitamin/Supplement Name: _____ Dosage: _____ Times Per Day: _____

Is the athlete able to adminster their own medications? ☐ No ☐ Yes

Athlete Medical Form – **PHYSICAL EXAM**

(To be completed by a Licensed Medical Professional qualified to conduct exams & prescribe medications)

Athlete's First and Last Name: _____

MEDICAL PHYSICAL INFORMATION

(To be completed by a Licensed Medical Professional qualified to conduct physical exams and prescribe medications)

Height	Weight	BMI *(optional)*	Temperature	Pulse	O_2Sat	Blood Pressure (in mmHg)		Vision
cm	kg	BMI	C			BP Right:	BP Left:	Right Vision 20/40 or better ☐ No ☐ Yes ☐ N/A
in	lbs	Body Fat %	F					Left Vision 20/40 or better ☐ No ☐ Yes ☐ N/A

Right Hearing (Finger Rub)	☐ Responds	☐ No Response	☐ Can't Evaluate		
Left Hearing (Finger Rub)	☐ Responds	☐ No Response	☐ Can't Evaluate		
Right Ear Canal	☐ Clear	☐ Cerumen	☐ Foreign Body		
Left Ear Canal	☐ Clear	☐ Cerumen	☐ Foreign Body		
Right Tympanic Membrane	☐ Clear	☐ Perforation	☐ Infection	☐ NA	
Left Tympanic Membrane	☐ Clear	☐ Perforation	☐ Infection	☐ NA	
Oral Hygiene	☐ Good	☐ Fair	☐ Poor		
Thyroid Enlargement	☐ No	☐ Yes			
Lymph Node Enlargement	☐ No	☐ Yes			
Heart Murmur (supine)	☐ No	☐ 1/6 or 2/6	☐ 3/6 or greater		
Heart Murmur (upright)	☐ No	☐ 1/6 or 2/6	☐ 3/6 or greater		
Heart Rhythm	☐ Regular	☐ Irregular			
Lungs	☐ Clear	☐ Not clear			
Right Leg Edema	☐ No	☐ 1+	☐ 2+	☐ 3+	☐ 4+
Left Leg Edema	☐ No	☐ 1+	☐ 2+	☐ 3+	☐ 4+
Radial Pulse Symmetry	☐ Yes	☐ R>L	☐ L>R		
Cyanosis	☐ No	☐ Yes, describe			
Clubbing	☐ No	☐ Yes, describe			

Bowel Sounds	☐ Yes	☐ No			
Hepatomegaly	☐ No	☐ Yes			
Splenomegaly	☐ No	☐ Yes			
Abdominal Tenderness	☐ No	☐ RUQ	☐ RLQ	☐ LUQ	☐ LLQ
Kidney Tenderness	☐ No	☐ Right	☐ Left		
Right upper extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia		
Left upper extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia		
Right lower extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia		
Left lower extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia		
Abnormal Gait	☐ No	☐ Yes, describe below			
Spasticity	☐ No	☐ Yes, describe below			
Tremor	☐ No	☐ Yes, describe below			
Neck & Back Mobility	☐ Full	☐ Not full, describe below			
Upper Extremity Mobility	☐ Full	☐ Not full, describe below			
Lower Extremity Mobility	☐ Full	☐ Not full, describe below			
Upper Extremity Strength	☐ Full	☐ Not full, describe below			
Lower Extremity Strength	☐ Full	☐ Not full, describe below			
Loss of Sensitivity	☐ No	☐ Yes, describe below			

SPINAL CORD COMPRESSION & ATLANTO-AXIAL INSTABILITY (AAI) *(Select one)*

☐ **Athlete shows NO EVIDENCE of neurological symptoms or physical findings associated with spinal cord compression or atlanto-axial instability.**

OR

☐ **Athlete has neurological symptoms or physical findings that could be associated with spinal cord compression or atlanto-axial instability and must receive an additional neurological evaluation to rule out additional risk of spinal cord injury prior to clearance for sports participation.**

ATHLETE CLEARANCE TO PARTICIPATE (*TO BE COMPLETED BY EXAMINER ONLY*)

Licensed Medical Examiners: It is recommended that the examiner review items on the medical history with the athlete or their guardian, prior to performing the physical exam. If an athlete needs further medical evaluation please make a referral below and second physician for referral should complete page 4.

☐ **This athlete is ABLE to participate in Special Olympics sports without restrictions.**

☐ **This athlete is ABLE to participate in Special Olympics sports WITH restrictions. Describe →** _____

☐ **This athlete MAY NOT participate in Special Olympics sports at this time & MUST be further evaluated by a physician for the following concerns:**

- ☐ Concerning Cardiac Exam
- ☐ Concerning Neurological Exam
- ☐ Other, please describe:
- ☐ Acute Infection
- ☐ Stage II Hypertension or Greater
- ☐ O_2 Saturation Less than 90% on Room Air
- ☐ Hepatomegaly or Splenomegaly

Additional Licensed Examiner's Notes and Recommended (but not required) Follow-up:

- ☐ Follow up with a cardiologist
- ☐ Follow up with a vision specialist
- ☐ Follow up with a podiatrist
- ☐ Follow up with a neurologist
- ☐ Follow up with a hearing specialist
- ☐ Follow up with a physical therapist
- ☐ Follow up with a primary care physician
- ☐ Follow up with a dentist or dental hygienist
- ☐ Follow up with a nutritionist
- ☐ Other/Exam Notes:

	Name:
	E-mail:
Signature of Licensed Medical Examiner Exam Date	Phone: - -

Athlete Medical Form – **MEDICAL REFERRAL FORM**

(To be completed by a Licensed Medical Professional only if referral is needed)

Athlete's First and Last Name: _____

This page only needs to be completed and signed if the physician on page three does not clear the athlete and indicates further evaluation is required.

Athlete should bring the previously completed pages to the appointment with the specialist.

Examiner's Name:_____

Specialty:_____

I have been asked to perform an additional athlete exam for the following medical concern(s) - *Please describe:*

☐ Concerning Cardiac Exam ☐ Acute Infection ☐ O_2 Saturation Less than 90% on Room Air

☐ Concerning Neurological Exam ☐ Stage II Hypertension or Greater ☐ Hepatomegaly or Splenomegaly

☐ Other, please describe:

In my professional opinion, this athlete MAY now participate in Special Olympics sports (indicate restrictions or limitations below):

☐ **Yes** ☐ **Yes, but with restrictions** ***(list below)*** ☐ **No**

Additional Examiner Notes/Restrictions:

Examiner E-mail: _____

Examiner Phone: _____

Examiner's Signature	**Date**

COVID-19 Participant Code of Conduct and Risk Assessment Form

Special Olympics Illinois

I understand I could get Coronavirus through sports, training, competition and/or any Special Olympics Illinois group activity. I am choosing to participate in sports, competition and/or other Special Olympics Illinois activities at my own risk.

During the time these precautions are needed, I agree to the following to help keep me and my fellow participants safe:

If I have COVID-19 symptoms, I will stay at home and NOT go to any activities until 7 days after all of my symptoms are over. If I am exposed to COVID-19 and have no symptoms, I can return 14 days after exposure.
Special Olympics Illinois gave me education on Special Olympics Illinois rules for COVID-19 and who is at high-risk.
I know that if I have a high-risk condition, I have more risk that I could get sick or die from COVID-19. If I have a high-risk condition, I should not go to Special Olympics Illinois events in person, until there is little or no Coronavirus in my community,
I know that before or when I get to a Special Olympics Illinois activity, they will ask me some questions about symptoms and exposure to COVID-19. They may also take my temperature. I will answer truthfully and participate fully.
I will keep at least 6 ft/2m from all participants at all times.
I will wear a mask at all times while at Special Olympics Illinois activities. I may not have to wear it during active exercise.
I will wash my hands for 20 seconds or use hand sanitizer before any activities. I will wash my hands any time I sneeze, cough, go to the bathroom or get my hands dirty.
I will avoid touching my face. I will cover my mouth when I cough or sneeze and immediately wash my hands after.
I will not share drinking bottles or towels with other people.
I will only share equipment when instructed to. If equipment must be shared, I will only touch the equipment if it is disinfected first.
If I get or have had COVID-19, I will not go to any in-person Special Olympics Illinois events until 7 days after my symptoms end. I will go to my doctor and get written clearance before returning to any sport or fitness activities.
I understand that if I do not follow all of these rules, I may not be allowed to participate in Special Olympics Illinois activities during this time.

SOILL RETAINS THE RIGHT TO MAKE THE FINAL DETERMINATION REGARDING ANY PARTICIPANTS INVOLVEMENT IN AN EVENT CONDUCTED BY SOILL.

I HAVE READ ALL OF THIS AGREEMENT OR HAVE HAD IT READ TO ME AND AGREE TO FOLLOW THESE ACTIONS.

PARTICIPANT FULL NAME: _____

Circle one: Athlete ☐ Unified Partner Coach/Volunteer ☐ Family/Caregiver ☐ Staff

Verbal consents or phone consents will not be accepted by Special Olympics Illinois.

PARTICIPANT SIGNATURE *(required for adult (age 18+) participants, including adult athlete with capacity to sign documents)*

By signing this, I acknowledge that I have completely read and fully understand the information in this form.

Signature: _____ **Date:** _____

PARENT/GUARDIAN SIGNATURE *(required for participant who is a minor (younger than age 18) or lacks capacity to sign documents)*

I am a parent or guardian of the athlete/participant named above. I have read and understand this form and have explained the contents to the participant as appropriate. By signing, I agree to this form on my own behalf and on behalf of the participant.

Parent/Guardian Signature: _____ **Date:** _____

Printed Name: _____

Relationship: _____

SPECIAL OLYMPICS ILLINOIS ATHLETE CONSENT, WAIVER AND RELEASE OF LIABILITY, ASSUMPTION OF RISK AND INDEMNIFICATION FORM

Athlete Name: Last _____ First _____

Athlete Date of Birth _____MM _____DD _____YY

Region _____ Agency Name_____

Are you a new athlete to Special Olympics Illinois or re-registering?

☐ New Athlete ☐ Re-Registering

Special Olympics Illinois - hereafter referred to as SOILL.

An athlete must also have a valid Medical Form on file with SOILL to be eligible to participate.

If individual is a new athlete submission or has a change in their guardianship status then an updated SOILL Consent Form must be submitted with the Medical Form.

I, on my own behalf or as the undersigned parent and/or legal guardian of the above named applicant (hereafter referred to as the "Entrant") do hereby:

- Request permission for the Entrant to participate in SOILL programs.
- Represent and warrant to you that Entrant is physically and mentally able to participate in SOILL sports training and competition.
- Acknowledge that SOILL will screen all entrants using the Sex Offender Public Registry and understand that entrants listed on the Registry will be denied participation. I affirm that this Entrant has never been on said Registry or, if Entrant was listed on said Registry but has since been removed, I will contact SOILL for instructions before submitting this form.
- Acknowledge that Entrants charged or convicted of a criminal offense are subject to SOILL's Eligibility Policy, and agree that SOILL may conduct a criminal background check in appropriate circumstances. Entrant further acknowledges that Entrant understands and will follow SOILL's Eligibility Policy.
- Acknowledge that Entrant understands and will execute and follow the Athlete Partner Code of Conduct.
- Acknowledge that Entrant understands and will execute and follow the COVID Code of Conduct.
- Acknowledge that Entrant understands that participation includes possible exposure to an illness from infectious and/or communicable diseases including but not limited to MRSA, influenza and COVID-19. While particular rules and personal discipline may reduce this risk, the risk of serious illness and death does exist; and, Entrant willingly agrees to comply with the stated and customary terms and conditions for participation as regards protection against infectious diseases. If, however, Entrant observes any unusual or significant hazard during presence or participation, Entrant will remove themselves from participation and bring such to the attention to the nearest official immediately.
- Acknowledge that Entrant understands there is a risk of injury and understands the risk of Entrant continuing to play sports with or after a concussion or other injury. Entrant may have to get medical care if they have a suspected concussion or other injury. Entrant may have to wait 7 days or more and get permission from a doctor before resuming sports activities.
- In permitting the Entrant to participate, I am specifically granting permission to SOILL and Special Olympics Inc. to use the likeness photo, video, name, voice, words and biographical information in television, radio, films, newspapers, magazines, social media and in any form not heretofore described for the purpose of advertising or communicating the purposes and activities of SOILL and Special Olympics Inc. in appealing for funds to support such activities.
- Consent for Entrant to participate in the SOILL Healthy Athlete Program that provides individual screening assessments of health status and health care needs. Entrant has no obligation to participate and I understand the Entrant should seek his/her/their own medical advice and assistance and SOILL is not responsible for the Entrant's health.
- For some events, Entrant may stay in a hotel, university type housing or someone's home. If I have questions I will ask.
- If I am unable, or my parent/guardian is unavailable, to consent or make medical decisions in an emergency, I authorize SOILL to seek medical care on my behalf.
- I understand that SOILL will be collecting Entrant's personal information as part of participation, including name, image, address, telephone number, health information and other provided personally identifying and health related information. Personal information may be used and shared consistent with this form and as further explained in the Special Olympics Inc.

Privacy Policy at www.SpecialOlympics.org/Privacy-Policy I further agree and consent to SOILL:

- Using Entrant personal information in order to: make sure Entrant is eligible and can participate safely; run trainings and events; share competition results (including on the Web and in news media); analyze data for the purpose of improving programming and identifying and responding to the needs of SOILL participants; perform computer operations, quality assurance, testing and other related activities; and provide event-related services.
- Using Entrant contact information for communicating with me about SOILL.
- Sharing information with medical professionals in an emergency or for injury treatment.

Entrants, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, HERBY FREELY AND VOLUNTARILY ASSUME ALL RISK, WAIVE AND RELEASE FROM LIABILITY, AGREE TO INDEMNIFY AND HOLD HARMLESS, Special Olympics Illinois, it's officers, officials, agents and/or employees, other participants, coaches, sponsoring agencies, sponsors, advertisers and if applicable, owners and lessors of the venue/premises used to conduct the event ("RELEASEES"), WITH RESPECT TO ANY AND ALL ILLNESS, DISABILITY, DEATH, or loss or damage to person or property, WHETHER ARISING FROM THE NEGLIGENCE OF RELEASEES OR OTHERWISE, to the fullest extent permitted by law.

I, THE UNDERSIGNED ADULT ENTRANT, have read and fully understand the provisions of the ATHLETE CONSENT, WAIVER AND RELEASE OF LIABIITY, ASSUMPTION OF RISK AND INDEMIFICATION FORM and/or have had them explained to me. I hereby agree that I will be bound thereby and I shall defend SOILL and hold it harmless from disaffirmation thereof.

Signature of Entrant _____

☐ Athlete is own guardian

Witness _____ Date _____

OR

FOR ENTRANTS OF MINORITY AGE (UNDER AGE 18 AT THE TIME OF REGISTRATION), OR THOSE WHO LACK LEGAL CAPACITY TO SIGN DOCUMENTS

This is to certify that I, as parent, guardian, and/or individual with legal responsibility for this Entrant, have read and explained the provisions in this ATHLETE CONSENT, WAIVER AND RELEASE OF LIABIITY, ASSUMPTION OF RISK AND INDEMIFICATION FORM to said Entrant including the risks of presence and participation, as well as their personal responsibilities to adhere to the rules and regulations promulgated by SOILL. Furthermore, said Entrant understands and accepts these risks and responsibilities. I, for myself, spouse (if applicable), and Entrant do herby consent and agree that said Entrant freely and voluntarily assumes all risk, and that we waive and release from liability, indemnify and hold harmless the above referenced RELEASEES for any and all liabilities incident to said Entrant's presence or participation in SOILL sports, training, competition and/or any other SOILL group activities as provided above, EVEN IF ARISING FROM THE RELEASEE'S NEGLIGENCE, OR OTHERWISE to the fullest extent provided by law.

Parent/Guardian/legally responsible individual's signature (required for Entrant who is a minor (younger than age 18) or otherwise lacks legal capacity to sign document).

Printed Name of parent/guardian/legally responsible individual: _____

Signature of parent/guardian/legally responsible individual: _____

Date: _____

Email address of Parent/Guardian/legally responsible individual:_____