

ATHLETE REGISTRATION FORM

Special Olympics



State Special Olympics Program: _____

Are you a new athlete to Special Olympics or Re-Registering? New Athlete Re-Registering

ATHLETE INFORMATION		
First Name:	Middle Name:	
Last Name:	Preferred Name:	
Date of Birth (mm/dd/yyyy):	Female	Male
Race/Ethnicity (Optional):		
American Indian/Alaskan Native	Asian	Two or More Races
Black or African American	Native Hawaiian or Other Pacific Islander	
White	Hispanic or Latino (specific origin group: _____)	
Language(s) Spoken in Athlete's Home (Optional): Check all that apply		
English	Spanish	Other (please list):
Street Address:		
City:	State:	Postal Code:
Phone:	E-mail:	
Sports/Activities:		
Athlete Employer, if any (Optional):		
Does the athlete have the capacity to consent to medical treatment on his or her own behalf? Yes No		
PARENT / GUARDIAN INFORMATION (required if minor or otherwise has a legal guardian)		
Name:		
Relationship:		
Same Contact Info as Athlete		
Street Address:		
City:	State:	Postal Code:
Phone:	E-mail:	
EMERGENCY CONTACT INFORMATION		
Same as Parent/Guardian		
Name:		
Phone:	Relationship:	
PHYSICIAN & INSURANCE INFORMATION		
Physician Name:		
Physician Phone:		
Insurance Company:	Insurance Policy Number:	
Insurance Group Number:		

ATHLETE RELEASE FORM

Special Olympics



I agree to the following:

1. **Ability to Participate.** I am physically able to take part in Special Olympics activities.
2. **Likeness Release.** I give permission to Special Olympics, Inc., Special Olympics games organizing committees, and Special Olympics accredited Programs (collectively "Special Olympics") to use my likeness, photo, video, name, voice, and words to promote Special Olympics and raise funds for Special Olympics.
3. **Risk of Concussion and Other Injury.** I know there is a risk of injury. I understand the risk of continuing to play sports with or after a concussion or other injury. I may have to get medical care if I have a suspected concussion or other injury. I also may have to wait 7 days or more and get permission from a doctor before I start playing sports again.
4. **Emergency Care.** If I am unable, or my guardian is unavailable, to consent or make medical decisions in an emergency, I authorize Special Olympics to seek medical care on my behalf, unless I mark one of these boxes:
 - I have a religious or other objection to receiving medical treatment. (Not common.)
 - I do not consent to blood transfusions. (Not common.)
 (If either box is marked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)
5. **Overnight Stay.** For some events, I may stay in a hotel or someone's home. If I have questions, I will ask.
6. **Health Programs.** If I take part in a health program, I consent to health activities, screenings, and treatment. This should not replace regular health care. I can say no to treatment or anything else at any time.
7. **Personal Information.** I understand that Special Olympics will be collecting my personal information as part of my participation, including my name, image, address, telephone number, health information, and other personally identifying and health related information I provide to Special Olympics ("personal information").
 - I agree and consent to Special Olympics:
 - using my personal information in order to: make sure I am eligible and can participate safely; run trainings and events; share competition results (including on the Web and in news media); provide health treatment if I participate in a health program; analyze data for the purposes of improving programming and identifying and responding to the needs of Special Olympics participants; perform computer operations, quality assurance, testing, and other related activities; and provide event-related services.
 - using my personal information and creating a profile of me for communications and marketing purposes, including direct digital marketing through email, SMS, social media, and other channels.
 - sharing my personal information with (i) researchers, business partners, public health agencies, and other organizations that are studying intellectual disabilities and the impact of Special Olympics activities, (ii) medical professionals in an emergency, and (iii) government authorities for the purpose of assisting me with any visas required for international travel to Special Olympics events and for any other purpose necessary to protect public safety, respond to government requests, and report information as required by law.
 - I understand Special Olympics is a global organization with headquarters in the United States of America. I acknowledge that my personal information may be stored and processed in countries outside my country of residence, including the United States. Such countries may not have the same level of personal data protection as my country of residence, and I agree that the laws of the United States will govern your processing of my personal information as provided in this consent.
 - I have the right to ask to see my personal information or to be informed about the personal information that is processed about me. I have the right to ask to correct and delete my personal information, and to restrict the processing of my personal information if it is inconsistent with this consent.
 - *Sharing of Personal Information.* Personal information may be shared consistent with this form and as further explained in the Special Olympics privacy policy at www.SpecialOlympics.org/Privacy_Policy.aspx.

Athlete Name:	E-mail:
ATHLETE SIGNATURE (required for adult athlete with capacity to sign legal documents)	
I have read and understand this form. If I have questions, I will ask. By signing, I agree to this form.	
Athlete Signature:	Date:
PARENT/GUARDIAN SIGNATURE (required for athlete who is a minor or lacks capacity to sign legal documents)	
I am a parent or guardian of the athlete. I have read and understand this form and have explained the contents to the athlete as appropriate. By signing, I agree to this form on my own behalf and on behalf of the athlete.	
Parent/Guardian Signature:	Date:
Printed Name:	Relationship:

ATHLETE LIKENESS RELEASE FOR SPONSORS (OPTIONAL)

Special Olympics



Special Olympics relies on sponsors and partners to help support our mission. We often use photos, videos and stories of our athletes to show the impact of support by companies that sponsor Special Olympics. If you wish to allow your likeness to be used in this way, please read and sign below.

I agree to the following:

- I give permission to Special Olympics, Inc., Special Olympics games organizing committees, and Special Olympics accredited Programs (collectively “Special Olympics”) and their sponsors and partners to use my likeness, photo, video, name, voice, and words (“my likeness”) to acknowledge the sponsors’ and partners’ support for Special Olympics.
- Special Olympics and its sponsors and partners will not use my Likeness to endorse commercial products or services.
- I understand I will not be compensated for the use of my Likeness.

Athlete Name:	E-mail:
ATHLETE SIGNATURE (required for adult athlete with capacity to sign legal documents)	
I have read and understand this form. If I have questions, I will ask. By signing, I agree to this form.	
Athlete Signature:	Date:
PARENT/GUARDIAN SIGNATURE (required for athlete who is a minor or lacks capacity to sign legal documents)	
I am a parent or guardian of the athlete. I have read and understand this form and have explained the contents to the athlete as appropriate. By signing, I agree to this form on my own behalf and on behalf of the athlete.	
Parent/Guardian Signature:	Date:
Printed Name:	Relationship:

Athlete Medical Form – HEALTH HISTORY

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

**Special
Olympics**



Athlete First & Last Name: _____ Preferred Name: _____

Athlete Date of Birth (mm/dd/yyyy): _____ Female Male

STATE PROGRAM: _____ E-mail: _____

ASSOCIATED CONDITIONS - Does the athlete have (check any that apply):

Autism	Down Syndrome	Fragile X Syndrome
Cerebral Palsy	Fetal Alcohol Syndrome	
Other Syndrome, please specify: _____		

ALLERGIES & DIETARY RESTRICTIONS

No Known Allergies
 Latex
 Medications: _____
 Insect Bites or Stings: _____
 Food: _____

ASSISTIVE DEVICES - Does the athlete use (check any that apply):

Brace	Colostomy	Communication Device
C-PAP Machine	Crutches or Walker	Dentures
Glasses or Contacts	G-Tube or J-Tube	Hearing Aid
Implanted Device	Inhaler	Pacemaker
Removable Prosthetics	Splint	Wheel Chair

List any special dietary needs:

SPORTS PARTICIPATION

List all Special Olympics sports the athlete wishes to play:

Has a doctor ever limited the athlete's participation in sports?

No Yes *If yes, please describe:*

SURGERIES, INFECTIONS, VACCINES

List all past surgeries:

Does the athlete currently have any chronic or acute infection?

No Yes *If yes, please describe:*

Has the athlete ever had an abnormal Electrocardiogram (EKG) or Echocardiogram (Echo)? *If yes, describe date and results*

Yes, had abnormal EKG
 Yes, had abnormal Echo

Has the athlete had a Tetanus vaccine in the past 7 years? No Yes

EPILEPSY AND/OR SEIZURE HISTORY

Epilepsy or any type of seizure disorder No Yes

If yes, list seizure type: _____

If yes, had seizure during the past year? No Yes

MENTAL HEALTH

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

Describe any additional mental health concerns:

FAMILY HISTORY

Has any relative died of a heart problem before age 50? No Yes

Has any family member or relative died while exercising? No Yes

List all medical conditions that run in the athlete's family:

Athlete Medical Form – HEALTH HISTORY

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



Athlete's First and Last Name: _____

HAS THE ATHLETE EVER BEEN DIAGNOSED WITH OR EXPERIENCED ANY OF THE FOLLOWING CONDITIONS

Loss of Consciousness	No	Yes	High Blood Pressure	No	Yes	Stroke/TIA	No	Yes
Dizziness during or after exercise	No	Yes	High Cholesterol	No	Yes	Concussions	No	Yes
Headache during or after exercise	No	Yes	Vision Impairment	No	Yes	Asthma	No	Yes
Chest pain during or after exercise	No	Yes	Hearing Impairment	No	Yes	Diabetes	No	Yes
Shortness of breath during or after exercise	No	Yes	Enlarged Spleen	No	Yes	Hepatitis	No	Yes
Irregular, racing or skipped heart beats	No	Yes	Single Kidney	No	Yes	Urinary Discomfort	No	Yes
Congenital Heart Defect	No	Yes	Osteoporosis	No	Yes	Spina Bifida	No	Yes
Heart Attack	No	Yes	Osteopenia	No	Yes	Arthritis	No	Yes
Cardiomyopathy	No	Yes	Sickle Cell Disease	No	Yes	Heat Illness	No	Yes
Heart Valve Disease	No	Yes	Sickle Cell Trait	No	Yes	Broken Bones	No	Yes
Heart Murmur	No	Yes	Easy Bleeding	No	Yes	Dislocated Joints	No	Yes
Endocarditis	No	Yes	If female athlete, list date of last menstrual period: _____					

Describe any past broken bones or dislocated joints

(if yes is checked for either of those fields above):

List any other ongoing or past medical conditions:

Neurological Symptoms for Spinal Cord Compression and Atlanto-axial Instability

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

PLEASE LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW

(includes inhalers, birth control or hormone therapy)

Medication, Vitamin or Supplement Name	Dosage	Times per Day	Medication, Vitamin or Supplement Name	Dosage	Times per Day	Medication, Vitamin or Supplement Name	Dosage	Times per Day

Is the athlete able to administer his or her own medications? No Yes

Name of Person Completing this Form	Relationship to Athlete	Phone	Email
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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 ₂ Sat	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			Bowel Sounds	Yes	No				
Left Hearing (Finger Rub)	Responds	No Response	Can't Evaluate			Hepatomegaly	No	Yes				
Right Ear Canal	Clear	Cerumen	Foreign Body			Splenomegaly	No	Yes				
Left Ear Canal	Clear	Cerumen	Foreign Body			Abdominal Tenderness	No	RUQ	RLQ	LUQ	LLQ	
Right Tympanic Membrane	Clear	Perforation	Infection	NA		Kidney Tenderness	No	Right	Left			
Left Tympanic Membrane	Clear	Perforation	Infection	NA		Right upper extremity reflex	Normal	Diminished	Hyperreflexia			
Oral Hygiene	Good	Fair	Poor			Left upper extremity reflex	Normal	Diminished	Hyperreflexia			
Thyroid Enlargement	No	Yes				Right lower extremity reflex	Normal	Diminished	Hyperreflexia			
Lymph Node Enlargement	No	Yes				Left lower extremity reflex	Normal	Diminished	Hyperreflexia			
Heart Murmur (supine)	No	1/6 or 2/6	3/6 or greater			Abnormal Gait	No	Yes, describe below				
Heart Murmur (upright)	No	1/6 or 2/6	3/6 or greater			Spasticity	No	Yes, describe below				
Heart Rhythm	Regular	Irregular				Tremor	No	Yes, describe below				
Lungs	Clear	Not clear				Neck & Back Mobility	Full	Not full, describe below				
Right Leg Edema	No	1+ 2+ 3+ 4+				Upper Extremity Mobility	Full	Not full, describe below				
Left Leg Edema	No	1+ 2+ 3+ 4+				Lower Extremity Mobility	Full	Not full, describe below				
Radial Pulse Symmetry	Yes	R>L	L>R			Upper Extremity Strength	Full	Not full, describe below				
Cyanosis	No	Yes, describe				Lower Extremity Strength	Full	Not full, describe below				
Clubbing	No	Yes, describe				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

Acute Infection

O₂ Saturation Less than 90% on Room Air

Concerning Neurological Exam

Stage II Hypertension or Greater

Hepatomegaly or Splenomegaly

Other, please describe:

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

Follow up with a cardiologist

Follow up with a neurologist

Follow up with a primary care physician

Follow up with a vision specialist

Follow up with a hearing specialist

Follow up with a dentist or dental hygienist

Follow up with a podiatrist

Follow up with a physical therapist

Follow up with a nutritionist

Other/Exam Notes:

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

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 O₂ 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 (<i>list below</i>)	No

Additional Examiner Notes/Restrictions:

Examiner E-mail: _____

Examiner Phone: _____

License: _____

Examiner's Signature	Date
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This section to be completed by Special Olympics staff only, if applicable.

This medical exam was completed at a MedFest event?	Yes	No
The athlete is a Unified Partner or a Young Athlete Participant?	Unified Partner	Young Athlete



Special Olympics Idaho - Safe Participation Plan
ATHLETE PROFILE

(Only to be completed if athlete has exhibited at any time Violent or Sexually Deviant behavior.)

Profile Date: _____

Athlete name: _____ SS# _____

Name of Person completing this profile: _____

Relationship to athlete: _____ Phone: _____

Parent / Guardian Name: _____ Phone: _____

Address: _____ City: _____

State: _____ Zip: _____ Does Athlete reside at this address? YES NO

Care Facility /Caregiver Name: _____ Phone: _____

Address: _____ State: _____ Zip: _____

How long has athlete resided at this address? Years _____ Months _____

Athlete Age: _____ Gender: M F Approx. Height: _____ Weight: _____

ATHLETE BEHAVIOR PROFILE

<u>Type of Behavior</u>	<u>Single or Multiple Incidents</u>	<u>Date of Last Incident</u>
Sexual Assault of Adult ----- M / F	Single / Multiple	_____
Sexual Exposure to Adult M / F	Single / Multiple	_____
Sexual Assault of child	Single / Multiple	_____
Sexual Exposure to child	Single / Multiple	_____
Sexual Harassment ----- M / F	Single / Multiple	_____
Physical Assault of adult ---- M / F	Single / Multiple	_____
Physical Assault of child	Single / Multiple	_____
Physical Self-abuse	Single / Multiple	_____
Verbal Assault	Single / Multiple	_____

Is the Athlete currently on legal probation? YES / NO If yes, describe the terms of probation.

Is athlete actively participating in a treatment program that specifically addresses the indicated behavior? YES / NO If YES, please describe treatment and frequency.

ATHLETE BEHAVIOR PROFILE

Cont'd.

Has a judge or other legal authority ordered this treatment? YES / NO

If YES, please describe any additional terms such as restriction of social activities.

Does athlete currently take medications for behavior modification? YES / NO

If YES, list Medications and Frequency: _____

Is there a specific stimulus / activity that has been identified as the trigger for the indicated behavior(s)?

YES / NO

Please list all behavior triggers and explain the circumstances of the most recent incident where athlete displayed the indicated behavior(s).

Describe athlete's understanding of his /her conduct – does athlete differentiate right from wrong behavior? Please explain. _____

Does the athlete currently display a positive, cooperative attitude under supervision? Please explain.

Please indicate athlete's communication skill level: check all that apply

- | | |
|---|---|
| <input type="checkbox"/> speech is clear, easily understood | <input type="checkbox"/> never speaks |
| <input type="checkbox"/> responds verbally when spoken to | <input type="checkbox"/> speech is not clear, difficult to understand |
| <input type="checkbox"/> does not usually speak | <input type="checkbox"/> uses sounds (not words) to communicate |
| <input type="checkbox"/> uses sign language only | <input type="checkbox"/> uses some words, some gestures |
| <input type="checkbox"/> usually maintains eye contact | <input type="checkbox"/> generally avoids eye contact |
| <input type="checkbox"/> other, explain _____ | |

Has individual participated in Special Olympics Idaho prior to today's date? YES / NO

If Yes, please list the team name(s), length of time athlete has participated, and in what sport(s).

SPECIAL OLYMPICS IDAHO ATHLETE'S CODE OF CONDUCT

Special Olympics Idaho is committed to the highest ideals of sports and expects all athletes to honor sports and Special Olympics. All Special Olympics athletes and Unified Partners agree to the following code:

I. SPORTSMANSHIP

- A.** I will practice good sportsmanship.
- B.** I will act in ways that bring respect to me, my coaches, my team and Special Olympics Idaho.
- C.** I will not use bad language.
- D.** I will not swear or insult other persons, this includes gossiping about other athletes or anyone involved with Special Olympics.
- E.** I will not fight with other athletes, coaches, volunteers, or staff.

II. TRAINING AND COMPETITION

- A.** I will train regularly.
- B.** I will learn and follow the rules of my sport.
- C.** I will listen to my coaches and the officials and ask questions when I do not understand.
- D.** I will always try my best during training, divisioning, and competitions.
- E.** I will not "hold back" in preliminaries just to get into an easier final heat.

III. RESPONSIBILITY FOR MY ACTIONS

- A.** I will not make inappropriate or unwanted physical, verbal or sexual advances on others.
- B.** I will not drink alcohol, smoke or take illegal drugs while representing Special Olympics at training sessions, competition or during Games.
- C.** I will not take drugs for the purpose of improving my performance.
- D.** I will obey all laws and Special Olympics rules.

I understand that if I do not obey this Code of Conduct my Program or a Games Organizing Committee may not allow me to participate.

Dated this _____ day of _____, 20____.

Athlete Name Print

Athlete Signature

Parent/Guardian Name Print

Parent/Guardian Signature

Special Olympics Family Member Code of Conduct

We hope as family members, you will embrace the spirit of Special Olympics and help to provide a competition and training environment that enhances athlete character and skill development. The following Family Code of Conduct should be emphasized during training, competition, and special events at any level – including sub-Program, Accredited Program, National, Regional and World.

As a Special Olympics family member, I pledge the following:

- I will let my athlete choose the sports in which he/she would like to participate. I will not force my choice upon him/her.
- I will remember that athletes participate to have fun and that the game is for them; not for the family members.
- I will see to it that my athlete's medical form is up-to-date, complete, and on file.
- I will learn the rules of the game and the SOI policies before I complain or protest.
- I (and my guests) will be a positive role model for my athlete and encourage sportsmanship by showing respect and courtesy, and by demonstrating positive support for all athletes, coaches, officials, and spectators at every game, practice, or competition.
- I understand that I play a vital role in the health and safety of my athlete's participation. I have a responsibility to assist Special Olympics in providing for the health and safety of all athletes by reporting suspicious behavior, talking to my child about personal safety, dropping off and picking up my child/guard from Special Olympics events at the times designated by the organization (not excessively earlier or later than said established times), and any and all other reasonable measures to assist in the protection of Special Olympics athletes.
- I (and my guests) will never engage in any kind of unsportsmanlike conduct, such as booing and taunting, refusing to shake hands, or using profane language and gestures with any official, coach, or family member.
- I will never encourage any behaviors or practices that would endanger the health and well-being of the athletes.
- I will teach my athlete to play by the rules and to resolve conflicts without resorting to hostility or violence.
- I will demand that my athlete treat other athletes, coaches, officials, and spectators with respect, regardless of race, creed, color, sex, or ability.
- I will teach my athlete that doing one's best is more important than winning, so that my athlete will never feel defeated by the outcome of a game or his/her performance.
- I will praise my athlete for competing fairly and trying hard, and I will make my athlete feel like a winner every time.
- I will never ridicule or yell at my athlete or other participants for making a mistake or losing a competition.
- I will emphasize skill development and practices, and how they benefit my athlete over winning. I will also de-emphasize games and competition in lower age groups.

- I will promote the emotional and physical well-being of the athletes ahead of any personal desire that I may have for my athlete to win.
- I will respect the officials and their authority during games and competition, and will never question, discuss, or confront coaches during competitions. Instead, I will take time to speak with coaches at an agreed upon time and place.
- I will demand a sports environment for my athlete that is free from drugs and alcohol, and I will refrain from their use at all sports events and competitions.
- I will smoke/chew tobacco only in designated areas.
- I will refrain from coaching my athlete or other athletes during competitions and practices if I am not the assigned coach.

As a Special Olympics Accredited Program family member, I also understand that if I fail to abide by the aforementioned rules and guidelines, I may be subject to disciplinary action that could include, but may not be limited to, the following:

- Verbal warning by officials, coaches, and/or sub-Program and Accredited Program personnel
- Game suspension with written documentation of incident kept on file in the Accredited Program Office
- Written warning
- Game forfeit through official or coach
- Season suspension
- Misbehavior Report submitted to Event Director

I hereby certify that I have reviewed, understood, and agreed to this Code of Conduct.

Signature of Family Member

Date

(Print)

Local Program/sub-Program

Athlete's Name