C.A.M.P. UNIVERSITY

Can Achieve Maximum Potential

Dear Prospective C.A.M.P. University Family:

We at C.A.M.P. University take a deep interest in ensuring that we can satisfactorily meet the needs of candidates who are being considered for admission to our Day Program. We want our campers to have a fun and enjoyable experience. We appreciate the time and effort needed to complete this application, and we are always willing to help you through this process should you require assistance. If you have any questions, please contact C.A.M.P. University at 956-800-5292.

Please return the completed application along with the required documents to C.A.M.P. University at 4200 N. Main St. in McAllen, or mail to P.O. Box 2294, McAllen TX 78502. After we have received these materials, our Admissions Committee will review the information and determine the suitability and placement of the potential candidate as a member of C.A.M.P. University. Once the application is reviewed we'd like to invite your student to attend C.A.M.P. University for three days as our guest. Please call our office at 956-800-5292 to make arrangements.

Thank you for your interest in C.A.M.P. University. We hope that we can be of service to you.

Sincerely,

Abbie Sasser
C.A.M.P. University Founder and Board Member

C.A.M.P. University does not discriminate on the basis of race, color, ethnicity, religion, age, or gender in its admissions policies or programs.

C.A.M.P. University Admission Documents Checklist

Please Include The Following Documents:

- ☐ Completed Admission Application
  Date Turned In To Office: _____
- ☐ Current Psychological Evaluation From High School Records
  (If Available I.E. Wechsler Intelligence Scale, Vineland Testing, Etc.)
- ☐ Current Medical Physical (Special Olympics Athletic Medical Form And Current TB SkinTest Or Chest X-Ray)
  *Please Note: We Require Physicals To Be Redone Every 3 Years. For Safety Reasons. (Whether Or Not CAMPers Participate In Special Olympics).
- ☐ Current List Of Medications
- ☐ Immunization Records (If Possible)
- ☐ Negative Result For TB Test (Tuberculosis)
- ☐ Signatures On:
  ____Photo Use Consent Form
  ____Parental Consent Waver Form For Field TripsHold Harmless Agreement
  ____Transportation Liability Release Form
- ☐ Completed Authorization Form For Background Check (Please Have You Driver's License And Social Security Card. Required For The Background Check.)
- ☐ Completed Automatic Draft Form

For Office Use Only

Dates of trial days: _____

Date of director and board approval: _____

C.A.M.P. UNIVERSITY

Application for Admission

(Please Print or Type)

Date: _____ Desired Date of Admission: _____

Past involvement with C.A.M.P. University _____

_____

How did you become aware of C.A.M.P. University? _____

_____

Candidate Information

Name: _____

Phone: _____

Address: _____

Date of Birth: _____ Place of Birth: _____

Social Security Number (last four digits) __ __ __ __

Gender: _____ Race: _____ Height: _____ Weight: _____

Primary language: _____ Secondary language(s): _____

Diagnosis (es): _____

_____

Briefly describe any physical disabilities or limitations that the admissions candidate may have:

_____

_____

Candidate's desired areas for improvement: _____

_____

Candidate's personal goals: _____

_____

_____

_____

Sponsor's goals/expectations for the candidate: _____

_____

_____

_____

Parent/Guardian Contact Information

Name: _____

Home Phone: _____ Business Phone: _____

Business Address: _____

Email: _____

Home Address: _____

Relationship to Candidate: _____

Employer: _____

Title: _____

Emergency Contact Information

Primary Contact: _____

Home Phone: _____

Business Phone: _____

E-mail: _____

Relation to Candidate: _____

Mailing Address: _____

Secondary Contact: _____

Home Phone: _____

Business Phone: _____

E-mail: _____

Relationship to Candidate: _____

Mailing Address: _____

Optional Family Information (e.g. relationship concerns, frequency of contact, etc.):

_____

_____

_____

Candidate's Educational and Residential History

Please indicate each type of educational program in which the candidate has participated and provide the details for each in the spaces below. Elaborate as needed to illustrate achievements or to identify areas for improvement. Continue on additional sheets if necessary.

Educational Background

1. Name of school or program _____

Dates/years attended _____

If candidate is not currently enrolled in this program, please explain the reason for leaving.

_____

_____

Briefly describe the candidate's overall educational experience with this program (strengths, areas for improvement, grades, etc.). _____

_____

_____

2. Describe candidate's formal education and any trade, technical, or vocational training: _____

_____

Employment History

Please complete this section of the application to describe all past employment by the candidate.

1. Employer's name: _____

   Job/duties performed: _____

   _____

   Dates of employment: _____

   Reasons for leaving: _____

2. Employer's name: _____

   Job/duties performed: _____

   _____

   Dates of employment: _____

   Reasons for leaving: _____

If the candidate has not had a job, please let us know if they received any job skills training in school.

_____

_____

_____

_____

What is the candidate's dream job?

_____

_____

_____

_____

_____

_____

Candidate's Health

Please list the types of medical coverage that the candidate has and provide the corresponding policy numbers (Insurances, Medicaid, Medicare, VA, etc.):

Name of Provider	Policy Number	Expiration/Renewal Date
_____	_____	_____
_____	_____	_____

Name of Candidate's Primary Care Physician: _____

Physician's Phone: _____

Address: _____

Special dietary needs:

_____

_____

Seizures:

Does the candidate have a history of seizures? ☐ yes ☐ no

If yes: Type of seizures (grand mal, petit mal, other): _____

Date of 1st seizure: _____ Date of most recent seizure: _____

Seizure frequency: ☐ daily ☐ weekly ☐ monthly ☐ semi-annually ☐ other

Are the seizures suppressed or controlled by prescribed medication(s)? ☐ yes ☐ no

Please list any limitations or risks that may result from a seizure: _____

_____

_____

Candidate's Medical History

Please examine the list below and note candidate's experiences with any of these factors or conditions. If possible, note the year of occurrence and elaborate briefly on the severity or frequency of the condition.

Circle one		Condition	Year(s)	Additional Description
yes	no	Speech disorders		
yes	no	High blood pressure		
yes	no	Heart problems		
yes	no	Diabetes		
yes	no	Cancer		
yes	no	Stroke		
yes	no	Kidney disease		
yes	no	Glaucoma		
yes	no	Arthritis		
yes	no	Sinus problems		
yes	no	Headaches		
yes	no	Hearing problems		
yes	no	Asthma		
yes	no	Digestive problems		
yes	no	Fainting		
yes	no	Balance problems		
yes	no	Menstrual problems		
yes	no	Muscular problems		

Circle one		Condition	Year(s)	Additional Description
yes	no	Polio		
yes	no	Pneumonia		
yes	no	Anemia		
yes	no	Chicken pox		
yes	no	Mumps		
yes	no	High cholesterol		
yes	no	Measles		
yes	no	Pregnancy		
yes	no	Hepatitis		
yes	no	Thyroid problems		
yes	no	Venereal disease		
yes	no	Swallowing difficulty		
yes	no	Head injury		
yes	no	Depression		
yes	no	Use of prosthetics, canes, walkers, lifts, and other devices		

Other significant health concerns: _____

_____

_____

Candidate's Religious Affiliations *(optional)*

Church/denominational preference: _____

Other religious interests/activities: _____

Candidate's Leisure and Recreation Interests

Hobbies: _____

Past Special Olympics activity: _____

_____

Level of participation in the sports listed above: _____

_____

Assistance/Guidance needed for any recreational activities: _____

_____

Favorite forms of entertainment: _____

_____

Personal and Social Development

Reading, speaking, listening strengths: _____

_____

Reading, speaking, listening limitations: _____

_____

Does the candidate socialize well with others? _____

How does he/she handle disagreements? _____

_____

Does the candidate have a history of aggression or threatening physical or verbal behavior?

☐ yes ☐ no If yes, please explain the frequency of this behavior, the possible causes/ environmental triggers, and the consequences of such activity. _____

_____

_____

Does the candidate feel remorse for his/her aggressive or threatening behavior? _____

_____

Activities of Daily Living

Can the candidate perform the following activities independently? If no, please include the level of assistance required (if applicable).

Mobility/ambulation: _____

_____

Communicating needs: _____

_____

Personal grooming and dressing: _____

_____

Orientation/Disorientation: _____

_____

Bowel and Bladder management: _____

_____

Eating: _____

_____

Social Étiquette (table manners/politeness) _____

_____

Awareness of time/day (clocks/calendars): _____

_____

Use of public transportation: _____

_____

Cooking: _____

_____

Laundry and house cleaning: _____

_____

Managing personal finances: _____

_____

Guardianship Statement

Complete either Section I or Section II below:

Section I

Attached is a copy of a court-executed guardianship order declaring _____

_____ to be the lawful guardian(s) of

_____.

_____ _____

Guardian/Sponsor Printed Name | Candidate Printed Name

_____ _____

Guardian/Sponsor Signature & Date | Candidate Signature / Date

Section II

I know of no court-executed guardianship order for _____.

_____ _____

Guardian/Sponsor Printed Name | Candidate Printed Name

_____ _____

Guardian/Sponsor Signature & Date | Candidate Signature / Date

Affirmation of Completeness and Accuracy of Application

Guardian/Sponsor: After you have provided the above information, please read the following statement and sign where indicated:

I/We, _____, hereby affirm that the information provided within the completed application is complete and accurate to the best of my/our knowledge.

_____ _____

Guardian/Sponsor Printed Name | Candidate Printed Name

_____ _____

Guardian/Sponsor Signature and Date | Candidate Signature and Date (if appropriate)

C.A.M.P.
UNIVERSITY

Transportation Liability Release Form

I, _____, being 21 years of age or older, do for myself and do hereby release, forever discharge and agree to hold harmless

(Name of Group) C.A.M.P. University and **(Trip Organizer)** C.A.M.P. University Staff

Transportation Volunteers

and the directors thereof from any and all liability, claims or demands for personal injury, sickness or death, as well as property damages and expenses, of any nature whatsoever which may be incurred by the undersigned that occur while said is participating in the above described transportation services, trip or activity.
Furthermore, I hereby assume all risk of personal injury, sickness, death, damage and expense as a result of participation in recreation and any related activities involved therein.
The undersigned further hereby agrees to hold harmless and indemnify said organization(s), its directors, employees and agents, for any liability sustained by said travel organizers as the result of negligent, willful or intentional acts of said participant, including expenses incurred attendant thereto.

Participant Signature

_____

Trip Participant Acknowledgement

I was provide and have read the above and understand the Rules of Conduct and will fully abide by them, as well as all additional instructions of the leadership of this trip, and activity directors.

This agreement is for any and all field trips organized by C.A.M.P. University

_____

_____

Parent or Legal Guardian

C.A.M.P. UNIVERSITY

Parental Consent & Waiver form for Field Trips

Permission is granted or my son/daughter to participate in the following field trip with C.A.M.P. University
Name: _____

I/We, hereby acknowledge that sufficient information has been provided by the C.A.M.P. University School with respect to planned activity, duration, location, method of transportation, participants and supervision.

I/We, hereby acknowledge that certain RISKS OF INJURY are inherent to participate in learning activities outside the school. These types of injuries may be minor or serious and may result from one's actions, or the actions or inaction of others, or a combination of both.

I/We understand that the Rules and Regulation established for the field trip are designed for the safety and protection of the participants and herby undertakes to inform my child to abide by these rules and regulations.

I/We understand that:

1. A minimum level of fitness and health (physical, mental and emotional), is required
2. Each person has a different capacity for participation: and
3. Any exceptions to full participation are identified on the Child Health Form.

I/We declare having read and understood the above Parental Consent Agreement in its entirely and hereby consent to allow my/our young adult to participate, acknowledging all of the foregoing.

_____	_____	_____
Parent or Legal Guardian Signature	**Date**	**Phone Number**

_____	_____
Emergency Contact	**Phone Number**

C.A.M.P. UNIVERSITY

Hold Harmless Agreement

The following named is a participant in C.A.M.P. University, (I, We) agree to hold C.A.M.P. University harmless from any losses to the participant or family member, physical, mental or financial which claims could arise at any time or place C.A.M.P. University has an activity or as a result of any activity or meeting.

It is further understood that C.A.M.P. University is to be held harmless for any and all claims which could be entered for sexual abuse and or sexual harassment as a result of activities or meeting associated with C.A.M.P. University.

It is further agreed that this document may be amended or replaced upon the direction for Insurance Company providing insurance protection for C.A.M.P. University.

In the event of any legal claim being filed against C.A.M.P. University by any participant or family member, current or past, C.A.M.P. University, its coordinator, and its board of director will be held harmless, leaving the claimant to pay any and all expenses which may arise for any legal action.

Signed for Participant

_____	_____	_____
Parent or Legal Guardian (circle one)	C.A.M.P. University Participant	Date

C.A.M.P. UNIVERSITY

C.A.M.P. University Members
Photo Use Consent Form

I, _____, give C.A.M.P. University permission to use
Parent or Legal Guardian

photos, and/or videos of _____ for public
C.A.M.P. University Participant

relation purposes on but not limited to: news articles, brochures, newsletters, social media, and/or presentations showing C.A.M.P. University activities to prospective new members, their families, or to prospective donors.

Signed for Participant

_____	_____	_____
Parent or Legal Guardian	C.A.M.P. University Participant	Date

C.A.M.P. UNIVERSITY
PO Box 2294 McAllen, TX 78502
956-800-5292
www.CAMPUniversity.org

August 10, 2021

To be a CAMPer at C.A.M.P. University, please be reminded of our first three requirements. A CAMPer must be able to feed him/herself on their own, to use the restroom on their own, and that there be no history of violence or aggression. We have a zero-tolerance policy for aggression or violence. To ensure that all CAMPers have a pleasant day at C.A.M.P. University, as well as to ensure the safety and well-being of your child, C.A.M.P. University is adopting some new policies. This will be so everyone can have a pleasant experience while at CAMP University.

- If a CAMPer becomes inconsolable at CAMP, or has a difficult day with yelling, wailing, or crying, the CAMPer will need to be picked up by a family member or family friend and be removed from CAMP University for the day.

- If a CAMPer has a restroom accident while attending CAMP University, a family member or family friend will need to come and pick up their CAMPer and take them home. If a CAMPer has more than 3 restroom accidents within a 6-month period, they will need to be removed from CAMP until the problem can be resolved. This does not include menstrual cycles.

- If there has been a change in the routine of a CAMPer that could prove to be upsetting to the CAMPer, C.A.M.P. University requests that we could be made aware of the change so that we can be prepared for helping the CAMPer deal with the changes.

_____ Parent's Signature

_____ Name of CAMPer

Physical and Medication Records

The following pages are required medical information for both C.A.M.P. University and Special Olympics. They are required for your loved one's safety whether or not they choose to participate in Special Olympics. We do require them to be updated every three years so that we can make accommodations as needed for your loved one and help them in the unlikely event of an emergency.

A parent or guardian can fill out the first four pages. A doctor must fill out the last two pages. Please be sure that the doctor signs and dates their forms.

The completed forms must be turned in at least eight weeks prior to a Special Olympics event for your loved one to be eligible to participate in that event.

Please fill out the medication list with all current medications only and let us know when a medication has changed so the list can be updated. Include any medications that are taken at home. In the event of an emergency we would need to let paramedics know what medications are taken and basic medical history. **Please keep medical forms updated.**

All information is kept confidential and under lock and key.

Please let us know if you have any questions about these forms.

ATHLETE REGISTRATION FORM

Special Olympics

State Special Olympics Program: OI.CAM.CampUniversity

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, words, and biographical information 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 contact information for communicating with me about Special Olympics.
     - 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.
   - *Privacy Policy.* Personal information may be used and shared consistent with this form and as further explained in the Special Olympics privacy policy at www.SpecialOlympics.org/Privacy-Policy.

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:**

WAIVER AND RELEASE OF LIABILITY, ASSUMPTION OF RISK AND INDEMNIFICATION AGREEMENT FOR COMMUNICABLE DISEASES
("Agreement") for
SPECIAL OLYMPICS

In consideration of being allowed to participate in any way in Special Olympics sports training, competition or fundraising activities, the undersigned acknowledges, appreciates, and agrees that:

1. Participation includes possible exposure to and 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,

2. I KNOWINGLY AND FREELY ASSUME ALL SUCH RISKS, both known and unknown, EVEN IF ARISING FROM THE NEGLIGENCE OF THE RELEASEES or others, and assume full responsibility for my participation; and,

3. I willingly agree to comply with the stated and customary terms and conditions for participation as regards protection against infectious diseases. If, however, I observe and any unusual or significant hazard during my presence or participation, I will remove myself from participation and bring such to the attention of the nearest official immediately; and,

4. I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, HEREBY RELEASE AND HOLD HARMLESS Special Olympics, Inc, Special Olympics *Texas* their officers, officials, agents, and/or employees, other participants, sponsoring agencies, sponsors, advertisers, and if applicable, owners and lessors of 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 HAVE READ THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IF FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

Name of Participant: _____

Participant Signature:_____

Date signed: _____

FOR PARTICIPANTS OF MINORITY AGE (UNDER AGE 18 AT THE TIME OF REGISTRATION)

This is to certify that I, as parent/guardian, with legal responsibility for this participant, have read and explained the provisions in this waiver/release to my child/ward including the risks of presence and participation and his/her personal responsibilities for adhering to the rules and regulations for protection against communicable diseases. Furthermore, my child/ward understands and accepts these risks and responsibilities. I for myself, my spouse, and child/ward do consent and agree to his/her release provided above for all the Releasees and myself, my spouse, and child/ward do release and agree to indemnify and hold harmless the Releasees for any and all liabilities incident to my minor child's/ward's presence or participation in these activities as provided above, EVEN IF ARISING FROM THEIR NEGLIGENCE, to the fullest extent provided by law.

Name of parent/guardian: _____

Parent guardian/signature:_____

Date signed: _____

Athlete Medical Form

Special Olympics

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

First name: _____ Last name: _____ Preferred name: _____

Date of birth (mm/dd/yyyy): ____/____/____ Gender: Female ☐ Male ☐ Other ☐

Email: _____ Phone number: _____ Mobile ☐ Landline ☐

Postal address: _____ Country: _____

Emergency Contact -

First name: _____ Last name: _____ Phone number: _____ Mobile ☐ Landline ☐

Relationship to athlete: Parent/guardian ☐ Caregiver ☐ Family member ☐ Healthcare provider ☐ Coach ☐ Other ☐

Qualifying and Associated Conditions - *Check all that apply:*

Associated Conditions	Autism ☐ Cerebral Palsy ☐ Down Syndrome ☐ Epilepsy ☐ Fragile X Syndrome ☐ Fetal Alcohol Syndrome ☐ Spina Bifida ☐ Marfan Syndrome ☐ Other ☐ None ☐
Please specify other known intellectual disability diagnoses	

Assistive Devices and Accommodations - *Do you use any of the following? (Check all that apply):*

Mobility	Walker ☐ Braces or crutches ☐ Wheelchair ☐ Prosthetics ☐ Removable orthotics ☐ None ☐
Lifestyle Aids	CPAP ☐ Colostomy ☐ Dentures ☐ Inhaler ☐ Glasses, contact lenses, or protective eyewear ☐ None ☐
Communications	Hearing aid ☐ Communication devices ☐ Sign language ☐ None ☐
Medical Devices	Implantable cardioverter defibrillator (ICD) ☐ Implantable device for seizure management ☐ VP shunt ☐ Spinal cord stimulator ☐ Pacemaker ☐ None ☐

List specific dietary requirements	
Other assistive devices and accommodations	

General Health Questions - *Have you ever been diagnosed with or experienced any of the following?*

High blood pressure	Yes ☐	No ☐	Heat illness	Yes ☐	No ☐
Cardiac condition	Yes ☐	No ☐	Coeliac disease	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Enlarged spleen	Yes ☐	No ☐
Kidney disease	Yes ☐	No ☐	Hearing impairment	Yes ☐	No ☐
Bleeding disorder	Yes ☐	No ☐	Visual impairment	Yes ☐	No ☐
Anemia	Yes ☐	No ☐	Osteoporosis	Yes ☐	No ☐
Asthma	Yes ☐	No ☐	Non-verbal	Yes ☐	No ☐
Have you ever had a head injury or concussion?				Yes ☐	No ☐
Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?				Yes ☐	No ☐
Has any family member or relative died of heart problems or of sudden death before age 50?				Yes ☐	No ☐
Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?				Yes ☐	No ☐
Have you had COVID-19? (Optional)				Yes ☐	No ☐
Have you been immunized for COVID-19? (Optional)				Yes ☐	No ☐

Do you have an allergy to any of the following?	Dust ☐ Food ☐ Insects ☐ Animals ☐ Plants ☐ Grasses ☐ Pollen ☐ Drugs or medicine ☐ Latex ☐ Other ☐ None ☐
Please specify allergies	

Have you had any surgeries?	Yes ☐	No ☐	If yes, please list all:
Did you ever have an abnormal Electrocardiogram (EKG) or Echocardiogram (ECHO)?	Yes ☐	No ☐	If yes, please specify:
Has a doctor ever limited your participation in sports?	Yes ☐	No ☐	If yes, please specify:
Do you have epilepsy or any type of seizure disorder?	Yes ☐	No ☐	If yes, please specify:
Have you had any broken bones or dislocated joints?	Yes ☐	No ☐	If yes, please specify:
Do you have liver disease?	Yes ☐	No ☐	If yes, please specify:
Do you have lung disease?	Yes ☐	No ☐	If yes, please specify:
Do you have heart disease?	Yes ☐	No ☐	If yes, please specify:
Do you have behavioral, mental health, and/or sensory conditions?	Yes ☐	No ☐	If yes, please specify:

Medication and Treatment - *Please list:*

Are you taking any prescription or over-the-counter medications or treatments? (Including birth control pills, insulin, multivitamins, allergy shots or pills, asthma inhalers, epilepsy medication, anti-inflammatory medication, supplements of any kind. etc.) Please list:

Medication, Vitamin, or Supplement Name	Dosage	Times per day

Medication, Vitamin, or Supplement Name	Dosage	Times per day

Eligibility to participate
Every person with an intellectual disability who is at least eight years of age is eligible to participate in Special Olympics. A person is considered to have an intellectual disability for purposes of determining his or her eligibility to participate in Special Olympics if that person satisfies any one of the following requirements: (1) The person has been identified by an agency or professional as having an intellectual disability as determined by their localities; or (2) The person has a cognitive delay, as determined by standardized measures such as intelligent quotient or "IQ" testing or other measures which are generally accepted within the professional community in that Accredited Program's nation as being a reliable measurement of the existence of a cognitive delay; or (3) The person has a closely related developmental disability. A "closely related developmental disability" means having functional limitations in both general learning (such as IQ) and in adaptive skills (such as in recreation, work, independent living, self-direction, or self-care). However, persons whose functional limitations are based solely on a physical, behavioral, or emotional disability, or a specific learning or sensory disability, are not eligible to participate as Special Olympics athletes, but may be eligible to volunteer for Special Olympics.

Today's date (mm/dd/yyyy): _____/_____/_____

Signature of person completing the form: _____

Is this form being completed by someone other than the athlete? Yes ☐ No ☐

If form is being completed by someone other than the athlete, please select the relationship to athlete.

Relationship to athlete: Parent/guardian ☐ Caregiver ☐ Family member ☐ Healthcare provider ☐ Coach ☐ Other ☐

MEDICAL PHYSICAL INFORMATION (TO BE COMPLETED BY EXAMINER ONLY)

To be completed by a Licensed Medical Professional qualified to conduct physical exams and prescribe medications. If necessary, please use additional pages to list anything else Special Olympics should know about this athlete.

Athlete first and last name: _____ Date of birth (mm/dd/yyyy): ____/____/____

Height (in/cm)	Weight (lb/kg)	Waist circumference (in/cm)	Temperature (°F/°C)	Pulse (bpm)	O2Sat (%)	Blood pressure (mmHG)		Vision (out of 20)	
						systolic	diastolic	os	od

Medical			
Eyes, ears, nose, and throat: include pupils, hearing	Normal ☐	Abnormal ☐	Findings:
Heart: include murmurs (auscultation standing, auscultation supine, and ± valsalva maneuver)	Normal ☐	Abnormal ☐	Findings:
Lungs	Normal ☐	Abnormal ☐	Findings:
Abdomen	Normal ☐	Abnormal ☐	Findings:
Skin: HSV, MRSA, or tinea corporis	Normal ☐	Abnormal ☐	Findings:
Neurological	Normal ☐	Abnormal ☐	Findings:
Musculoskeletal			
Neck	Normal ☐	Abnormal ☐	Findings:
Back	Normal ☐	Abnormal ☐	Findings:
Shoulder and arm	Normal ☐	Abnormal ☐	Findings:
Elbow and forearm	Normal ☐	Abnormal ☐	Findings:
Wrist, hand, and fingers	Normal ☐	Abnormal ☐	Findings:
Hip and thigh	Normal ☐	Abnormal ☐	Findings:
Knee	Normal ☐	Abnormal ☐	Findings:
Lower leg and ankle	Normal ☐	Abnormal ☐	Findings:
Foot and toes	Normal ☐	Abnormal ☐	Findings:

MEDICAL ELIGIBILITY FOR SPORT *(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 provide information regarding the licensed healthcare provider below. That provider should complete a referral below and second physician for referral should complete page 4.

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of: _____

☐ Not medically eligible pending further evaluation of: _____

☐ Not medically eligible to participate in the following sports: _____

☐ Not medically eligible for any sports

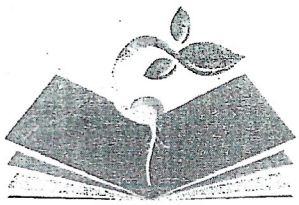
I have examined the athlete named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date (mm/dd/yyyy): ____/____/____

Address: _____ Phone: _____

Signature of health care professional: _____

NPI or License number: _____ License type (MD, DO, NP, or PA): _____



C.A.M.P.
UNIVERSITY

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PO Box 2294 McAllen, TX 78502
956-800-5292
www.CAMPUniversity.org

Medical Diagnosis Form

Name of Patient:_____

Physician:_____Physician's Phone:_____

Physician's Address:_____City/State/Zip_____

This patient has (check all that apply) ( )Autism ( )Down Syndrome ( )Fragile X Syndrome
( )Cerebral Palsy ( )Fetal Alcohol Syndrome
( )Other syndrome (*please specify*): _____

Medical Examiner Sign and Date
Signature of Licensed Physician, Physician's Assistant licensed by State Board of Physicians Assistant Examiners, or Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners.

_____Date_____

_____
Printed Name

_____
License

_____
Phone

Page to be completed by medical examiner

Medication Record

Name of CAMPer: _____

Date Perscribed	Date Stopped	Medication	Dosage	Frequency (i.e. 2x per day)	Time	AM / PM	Reason

For C.A.M.P. University Use Only

C.A.M.P. UNIVERSITY

Automatic Draft Form

Family Information(required) Please Print in Capital Letters

Student Name : _____ | Phone #: _____

DOB: _____ | Email: _____

Parents or Checking Account Holder (Please write below)

Name: _____ Street Address: _____

City: _____ State: _____ County: _____

Authorization Agreement for Automatic Draft

I hereby authorize **Camp University** to initiate automatic withdrawals from my account at the financial institution named below. Monthly Payment of: __$_____

Further, I agree not to hold **Camp University** responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until **Camp University** receives a written notice of cancellation from me or my financial institution.

Please Select One Payment Option Listed Below

A. ( ) I want you to Transfer Payments Monthly from my Bank Account

Account Information

Name of Financial Institution: _____

Routing Number : ___ ___ ___ ___ ___ ___ ___ ___ ___ **(9 numbers)**

Account Number: o Checking o Savings

Signature

Authorized Signature: **Date:**

B. ( ) I want you to Transfer Payments Monthly from My Credit Card

Account Information

Credit Card Account #:

Expiration Date: _____ / _____ **3 Digit Code (on the back of card)**_____

Credit Card Type: **Visa** ___ **MasterCard** ___ **Discover** ___ **Amex** ___

Signature

Authorized Signature: **Date:**

Please keep this receipt for future reference