



**Special Olympics**  
**Ohio**  
**Greater Dayton**

**TO: ALL COACHES**  
**FROM: Tom Lindstrom, Swim Meet Coordinator**

The Area 2 Swim Meet for 2010 will once again be hosted by Montgomery County at Wright State University. The date is Friday, October 08, 2010, and the time is 5:00 p.m. for registration. This event will last until approximately 8:00 p.m.

**PLEASE NOTE: REGISTRATION WILL BE AT 5:00 P.M. and EVENT WILL BEGIN AT 6:00 P.M.**

The events offered this year are:

FLOTATION	15	meter (exhibition event only)
FREESTYLE	25	meter
BACKSTROKE	25	meter
BREASTSTROKE	25	meter
BUTTERFLY	25	meter
FREESTYLE	50	meter
BACKSTROKE	50	meter
BREASTSTROKE	50	meter
BUTTERFLY	50	meter
FREESTYLE	100	meter
BACKSTROKE	100	meter
BREASTSTROKE	100	meter
BUTTERFLY	100	meter
INDIVIDUAL MEDLEY	100	meter
FREESTYLE	200	meter
BACKSTROKE	200	meter
FREESTYLE	4X25	meter relay
MEDLEY	4X25	meter relay
FREESTYLE	4X50	meter relay

**PRACTICES HAVE BEEN SCHEDULED AT THE WRIGHT STATE UNIVERSITY POOL FOR:**

Saturday	September 18, 2010	11:00 – 12:00
Saturday	September 25, 2010	11:00 – 12:00
Saturday	October 02, 2010	11:00 – 12:00

**PLEASE NOTE: ALL ATHLETES ATTENDING PRACTICES MUST BE ACCOMPANIED BY A COACH, PARENT OR GUARDIAN. WE WILL NOT ALLOW ANY ATHLETE TO BE SIMPLY "DROPPED OFF" FOR PRACTICE.**





***Special Olympics***  
***Ohio***  
***Greater Dayton***

***2010 AREA 2 AQUATICS MEET REGISTRATION FORM***

***REGISTRATION DEADLINE IS SEPTEMBER 27, 2010***

***NO REGISTRATIONS WILL BE ACCEPTED AFTER SEPTEMBER 27, 2010 @ 5:00 P.M.***

***NO EXCEPTIONS***





***Special Olympics***  
***Ohio***  
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**SPECIAL OLYMPICS SWIM PRACTICE**

**WILL BE HELD**

**SATURDAY**

**SEPTEMBER 18**

**SATURDAY**

**SEPTEMBER 25**

**SATURDAY**

**OCTOBER 02**

**FROM 11:00-12:00**

**AT**

**THE WRIGHT STATE UNIVERSITY SWIMMING POOL**

**THESE ARE FREE PRACTICES**

**AREA 2 EVENT WILL BE HELD  
FRIDAY, OCTOBER 08, 2010 AT 6:00 P.M.**

- All athletes must have a current medical on file with Special Olympics in order to practice.
- There will be no drop off of athletes. Please plan to stay with your athlete the entire time.
- Questions may be referred to the Special Olympics office @ 258-5353.



# 2010 AREA 2 AQUATICS MEET REGISTRATION FORM

COUNTY: \_\_\_\_\_ ORGANIZATION: \_\_\_\_\_  
 ATHLETE'S LAST NAME \_\_\_\_\_ FIRST \_\_\_\_\_  
 SEX: (Circle One)      MALE      FEMALE  
 ATHLETE'S BIRTHDAY      (Day) \_\_\_\_\_ (Month) \_\_\_\_\_ (Year) \_\_\_\_\_

DOES THIS ATHLETE NEED OUTSIDE LANE? YES or NO (reason) \_\_\_\_\_  
 DOES THIS ATHLETE NEED AN IN-POOL START? YES or NO (reason) \_\_\_\_\_

**DIRECTIONS:** Prepare this form for each of your Special Olympics Athletes and Partners. Athletes may enter two (2) events plus a Relay. Partners may enter two (2) different relay events. Please circle EVENT CODE number of the event(s) entered. Please round off times to whole tenths.

EVENT CODE	EVENT DESCRIPTION	AREA QUALIFYING SCORE
AQ25FR	25 m FREESTYLE	min <input type="checkbox"/> sec <input type="checkbox"/> <input type="checkbox"/> tenths <input type="checkbox"/>
AQ25BK	25 m BACKSTROKE	min <input type="checkbox"/> sec <input type="checkbox"/> <input type="checkbox"/> tenths <input type="checkbox"/>
AQ25BR	25 m BREASTSTROKE	min <input type="checkbox"/> sec <input type="checkbox"/> <input type="checkbox"/> tenths <input type="checkbox"/>
AQ25BF	25 m BUTTERFLY	min <input type="checkbox"/> sec <input type="checkbox"/> <input type="checkbox"/> tenths <input type="checkbox"/>
AQ50FR	50 m FREESTYLE	min <input type="checkbox"/> sec <input type="checkbox"/> <input type="checkbox"/> tenths <input type="checkbox"/>
AQ50BK	50 m BACKSTROKE	min <input type="checkbox"/> sec <input type="checkbox"/> <input type="checkbox"/> tenths <input type="checkbox"/>
AQ50BR	50 m BREASTSTROKE	min <input type="checkbox"/> sec <input type="checkbox"/> <input type="checkbox"/> tenths <input type="checkbox"/>
AQ50BF	50 m BUTTERFLY	min <input type="checkbox"/> sec <input type="checkbox"/> <input type="checkbox"/> tenths <input type="checkbox"/>
AQ1CFR	100 m FREESTYLE	min <input type="checkbox"/> sec <input type="checkbox"/> <input type="checkbox"/> tenths <input type="checkbox"/>
AQ1CBK	100 m BACKSTROKE	min <input type="checkbox"/> sec <input type="checkbox"/> <input type="checkbox"/> tenths <input type="checkbox"/>
AQ1CBR	100 m BREASTSTROKE	min <input type="checkbox"/> sec <input type="checkbox"/> <input type="checkbox"/> tenths <input type="checkbox"/>
AQ1CBF	100 m BUTTERFLY	min <input type="checkbox"/> sec <input type="checkbox"/> <input type="checkbox"/> tenths <input type="checkbox"/>
AQ1CIM	100 m INDIVIDUAL MEDLEY	min <input type="checkbox"/> sec <input type="checkbox"/> <input type="checkbox"/> tenths <input type="checkbox"/>
AQ2CFR	200 m FREESTYLE	min <input type="checkbox"/> sec <input type="checkbox"/> <input type="checkbox"/> tenths <input type="checkbox"/>
AQ2CBK	200 m BACKSTROKE	min <input type="checkbox"/> sec <input type="checkbox"/> <input type="checkbox"/> tenths <input type="checkbox"/>
4X25FR	TRADITIONAL 4X25 m FREESTYLE RELAY	USE RELAY FORM
4X25UN	UNIFIED 4X25 m FREESTYLE RELAY	USE RELAY FORM
4X25ME	TRADITIONAL 4X25 m MEDLEY RELAY	USE RELAY FORM
4X25MU	UNIFIED 4X25 m MEDLEY RELAY	USE RELAY FORM
4X50FR	TRADITIONAL 4X50 m FREESTYLE	USE RELAY FORM
4X50UN	UNIFIED 4X50 m FREESTYLE	USE RELAY FORM
EXIB15	15 m FLOTATION	min <input type="checkbox"/> sec <input type="checkbox"/> <input type="checkbox"/> tenths <input type="checkbox"/>

# RELAY ENTRY FORM

COUNTY/ORGANIZATION \_\_\_\_\_

SEX (circle one)

MALE

FEMALE

EVENT (circle one)

## TYPE

4 X 25 M FREESTYLE RELAY	TRADITIONAL	UNIFIED
4 X 25 M MEDLEY RELAY	TRADITIONAL	UNIFIED
4 X 50 M FREESTYLE RELAY	TRADITIONAL	UNIFIED

Note: Swimmers should be placed in the order in which they swim. If entering unified relay, mark "P" in parenthesis after the partner's name(s).

NAME

SEX

- |    |       |       |
|----|-------|-------|
| 1. | _____ | _____ |
| 2. | _____ | _____ |
| 3. | _____ | _____ |
| 4. | _____ | _____ |

ENTRY TIME: Minutes \_\_\_\_\_ Seconds \_\_\_\_\_ Tenths \_\_\_\_\_

Alternates: can be athlete or partner for only 1 relay

- |    |       |       |
|----|-------|-------|
| 1. | _____ | _____ |
| 2. | _____ | _____ |

**REGISTRATION DEADLINE IS September 27, 2010**

**NO REGISTRATIONS WILL BE ACCEPTED AFTER September 27 2010 @ 5:00 P.M.**

**NO EXCEPTIONS**



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**THE GAMES RULES COMMITTEE SHALL MAKE ALL FINAL  
DECISIONS**

- (1) Standing on the bottom of the pool during freestyle event or during freestyle portion of the medley event shall not disqualify a competitor, but he/she shall not walk.**
- (2) Standing upon the bottom in the racing course is allowed only for the purpose of resting. Walking on or jumping from the bottom must disqualify the competitor.**
- (3) If a swimmer does not choose to start the race from the diving blocks, please notify the bullpen director. Swimmers may start from the side of the pool or in the pool.**
- (4) A Coach or Official may guide the swimmer by voice only. The aid is not allowed to touch the swimmer from the time of the starting signal until all swimmers have completed the race.**
- (5) No competitor shall be permitted to use or wear any device that may aid his speed, buoyancy or endurance during a competition (except flotation events) such as webbed gloves, flippers, fins, etc. Goggles may be worn.**
- (6) Any special instructions or medical concerns must be submitted on registration form.**

**ALL REGISTERED ATHLETES MUST HAVE A CURRENT MEDICAL  
ON FILE OR SUBMIT ONE PRIOR TO THE FIRST PRACTICE DATE.**



**SPECIAL OLYMPICS OHIO APPLICATION FOR PARTICIPATION (Revised 2002)**

**DEMOGRAPHICS**

COUNTY: \_\_\_\_\_

ORGANIZATION: \_\_\_\_\_  Male Date of Birth (month/day/year) \_\_\_\_\_  
 Athlete's Name \_\_\_\_\_  Female \_\_\_\_\_

Athlete's Address \_\_\_\_\_ Athlete Home Phone # \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Parent/Guardian's Name \_\_\_\_\_ Parent Primary Phone # \_\_\_\_\_  
 Parent/Guardian's Address (if different than athlete) \_\_\_\_\_ Parent Secondary Phone # \_\_\_\_\_

Emergency Contact (if other than parent/guardian) \_\_\_\_\_ Primary Phone # \_\_\_\_\_  
 Health/Accident Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

**HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER**

Yes <input type="checkbox"/>	No <input type="checkbox"/>	Heart disease / heart defect / high blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Allergy: _____
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Medicines: _____
<input type="checkbox"/>	<input type="checkbox"/>	Seizures / epilepsy/fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	Food: _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Insect stings/bites: _____
<input type="checkbox"/>	<input type="checkbox"/>	Concussion or serious head injury	<input type="checkbox"/>	<input type="checkbox"/>	Special diet
<input type="checkbox"/>	<input type="checkbox"/>	Major surgery or serious illness	<input type="checkbox"/>	<input type="checkbox"/>	*Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Heat stroke / exhaustion	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco use
<input type="checkbox"/>	<input type="checkbox"/>	Blindness / visual problem	<input type="checkbox"/>	<input type="checkbox"/>	Easy bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Contact lenses / glasses	<input type="checkbox"/>	<input type="checkbox"/>	Emotional / psychiatric / behavioral
<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss / hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell trait or disease
<input type="checkbox"/>	<input type="checkbox"/>	Bone or joint problem	<input type="checkbox"/>	<input type="checkbox"/>	Immunizations up to date

Date of most recent tetanus immunization \_\_\_\_/\_\_\_\_/\_\_\_\_   Other (For additional space, use back of form): \_\_\_\_\_

A physical examination by a licensed physician is required every three (3) years  
 If the local program has a reasonable basis for believing that there has been a significant change in the athlete's health since this history and physical examination, then the athlete shall be required to seek medical advice & submit a new application form before further Special Olympics participation.

**Medications:**  
 Please print medication name, amount, date prescribed and number of times per day medication is given. Attach separate sheet if necessary.

Medication Name	Dosage	Date Prescribed	Times per day	Medication Name	Dosage	Date Prescribed	Times per day

Signature of parent/caregiver/adult athlete: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**ATLANTO-AXIAL INSTABILITY ASSESSMENT FOR ATHLETES WITH DOWN SYNDROME**

EXAMINER'S NOTE: If the athlete has Down syndrome, Special Olympics requires a full radiological examination establishing the absence of Atlanto-axial instability before he/she may participate in sports or events which, by their nature, may result in hyperextension, radical flexion or direct pressure on the neck or upper spine. The sports and events for which such a radiological examination is required are: judo, equestrian sports, gymnastics, diving, pentathlon, butterfly stroke and diving starts in swimming, high jump, alpine skiing, snowboarding, squat lift, and football team competition (soccer).

Yes  No

Has an x-ray evaluation for atlanto-axial instability been done?  
  If yes, was it positive for atlanto-axial instability? (positive indicates that the atlanto-dens interval is 5mm or more)

**PHYSICAL EXAMINATION**

Blood pressure: \_\_\_\_/\_\_\_\_ Weight: \_\_\_\_ Height: \_\_\_\_

Normal/Abnormal	Normal/Abnormal	Normal/Abnormal
<input type="checkbox"/> <input type="checkbox"/> Vision	<input type="checkbox"/> <input type="checkbox"/> Cardiovascular system	<input type="checkbox"/> <input type="checkbox"/> Cranial nerves
<input type="checkbox"/> <input type="checkbox"/> Hearing	<input type="checkbox"/> <input type="checkbox"/> Respiratory system	<input type="checkbox"/> <input type="checkbox"/> Coordination
<input type="checkbox"/> <input type="checkbox"/> Oral cavity	<input type="checkbox"/> <input type="checkbox"/> Gastrointestinal system	<input type="checkbox"/> <input type="checkbox"/> Reflexes
<input type="checkbox"/> <input type="checkbox"/> Neck	<input type="checkbox"/> <input type="checkbox"/> Genitourinary system	
<input type="checkbox"/> <input type="checkbox"/> Extremities	<input type="checkbox"/> <input type="checkbox"/> Skin	

Other: \_\_\_\_\_

I have reviewed the above health information and have performed the above examination on this athlete within the past 6 months and certify that the athlete can participate in Special Olympics. Any significant change to the above information requires a new examination prior to any participation.

RESTRICTIONS: \_\_\_\_\_

EXAMINER'S SIGNATURE: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

EXAMINER'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

# OFFICIAL SPECIAL OLYMPICS RELEASE FORM

## RELEASE TO BE COMPLETED BY ADULT ATHLETE

I, \_\_\_\_\_ am at least 18 years old and have submitted the attached application for participation in Special Olympics.

I represent and warrant that, to the best of my knowledge and belief, I am physically and mentally able to participate in Special Olympics activities. I also represent that a licensed physician has reviewed the health information contained in my application and has certified, based on an independent medical examination, that there is no medical evidence which would preclude me from participating in Special Olympics. I understand that if I have Down Syndrome, I cannot participate in sports or events which, by their nature, result in hyper-extension, radical flexion or direct pressure on my neck or upper spine unless I and two physicians have completed the official "Special Release for Athletes with Atlanto-Axial Instability," available from the Special Olympics Chapter program in my state, or I have had a full radiological examination which establishes the absence of Atlanto-axial Instability. I am aware that if I choose not to complete the "Special Release for Athletes with Atlanto-Axial Instability" form, which establishes the absence of Atlanto-axial Instability, I must have the radiological examination before I can participate in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, and soccer.

Special Olympics has my permission, (both during and anytime after), to use my likeness, name, voice or words in either television, radio, film, newspapers, magazines, and other media, and in any form, for the purpose of advertising or communicating the purposes and activities of Special Olympics and/or applying for funds to support these purposes and activities.

If, during my participation in Special Olympics activities, I should need emergency medical treatment, and I am not able to give my consent or make my own arrangements for that treatment because of my injuries, I authorize Special Olympics to take whatever measures are necessary to protect my health and well-being, including, if necessary, hospitalization.

I, the athlete named above, have read this paper and fully understand the provisions of the release that I am signing. I understand that by signing this paper, I am saying that I agree to the provisions of this release.

\_\_\_\_\_  
Signature of Adult Athlete

\_\_\_\_\_  
Date

I hereby certify that I have reviewed this release with the athlete whose signature appears above. I am satisfied based on that review that the athlete understands this release and has agreed to its terms.

Name (Print) \_\_\_\_\_

Relationship to athlete \_\_\_\_\_

(e.g. family member, teacher, coach, etc.)

## RELEASE TO BE COMPLETED BY Parent or Guardian of minor athlete

I am the parent/guardian of \_\_\_\_\_, the minor athlete, on whose behalf I have submitted the attached application for participation in Special Olympics. I hereby represent that the athlete has my permission to participate in Special Olympics activities.

I further represent and warrant that to the best of my knowledge and belief, the athlete is physically and mentally able to participate in Special Olympics. With my approval, a licensed physician has reviewed the health information set forth in the athlete's application, and has certified based on an independent medical examination that there is no medical evidence, which would preclude the athlete's participation. I understand that if the athlete has Down Syndrome, he/she cannot participate in sports or events, which, by their nature, result in hyper-extension, radical flexion or direct pressure on the neck or upper spine, unless I and two physicians have completed the official "Special Release for Athletes with Atlanto-Axial Instability." Available from the Special Olympics Chapter program in my state, or the athlete has had a full radiological examination, which establishes the absence of Atlanto-axial Instability. I am aware that if I choose not to complete the "Special Release for Athletes with Atlanto-Axial Instability" form, which establishes the absence of Atlanto-axial Instability, the athlete must have the radiological examination before he/she can participate in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, and soccer.

In permitting the athlete to participate, I am specifically granting my permission, (both during and anytime after), to Special Olympics to use the athlete's likeness, name, voice and words in television, radio, film, newspapers, magazines and other media, and in any form, for the purpose of advertising or communicating the purposes and activities of Special Olympics and/or applying for funds to support those purposes and activities.

If a medical emergency should arise during the athlete's participation in any Special Olympics activities, at a time when I am not personally present so as to be consulted regarding the athlete's care, I hereby authorize Special Olympics, on my behalf, to take whatever measures are necessary to ensure that the athlete is provided with any emergency medical treatment, including hospitalization, which Special Olympics deems advisable in order to protect the athlete's health and well-being.

I am the parent (guardian) of the athlete named in this application. I have read and fully understand the provisions of the above release, and have explained these provisions to the athlete. Through my signature on this release form, I am agreeing to the above provisions on my own behalf and on the behalf of the athlete named above.

I hereby give my permission for the athlete named above to participate in Special Olympics games, recreation programs, and physical activity programs.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date