



FORM B - SPECIAL CONDITIONS INFORMATION FORM

NAME OF PARTICIPANT _____

PLEASE CHECK

CONDITION		NO	YES
	This section is to be completed by a parent, guardian, caregiver, counselor, physician, physical therapist, occupational therapist or education/teacher who is familiar with the ability level and limitations of the participant		
1	VISUAL OR HEARING IMPAIRMENT		
2	DIFFICULTY IN COMPREHENDING INSTRUCTIONS		
3	SEVERE ALLERGIES (EPINEPHRINE REQUIRED)		
4	DEVELOPMENTALLY DELAYED		
5	ATTENTION DEFICIT DISORDER		
6	ASTHMATIC (prone to attacks)		
7	PROSTHESIS		
8	LIMITED RANGE OF MOTION DUE TO INJURY, SURGERY, OR OTHER <i>Specify</i>		
9	ANY OTHER CONDITION THAT IS NOT ALREADY LISTED AND SHOULD BE DISCLOSED <i>Specify</i>		
<i>Form completed by (print name):</i> _____ <i>Signature:</i> _____ <i>Relationship to participant:</i> _____ <i>Date:</i> _____			
CONDITION		NO	YES
	This section must be completed by a physician, physical therapist, occupational therapist, or person qualified to conduct functional assessments of the participant		
1	SPINA BIFIDA		
2	CEREBRAL PALSY		
3	MUSCULAR DYSTROPHY		
4	HYDROCEPHALUS (SHUNT)		
5	VISUAL IMPAIRMENT		
6	POLIO		
7	AUTISM		
8	PREDISPOSITION TO SEIZURES		
9	USHER'S SYNDROME		
10	ANY OTHER CONDITION THAT COULD RESULT IN POSSIBLE LIMITATIONS DURING PARTICIPATION IN A GYMNASTIC CLASS <i>Specify</i>		
11	DOWNS SYNDROME - If yes, please complete atlanto-axial section		
<i>Form completed by (print name):</i> _____ <i>Signature:</i> _____ <i>Relationship to participant:</i> _____ <i>Date:</i> _____			

FORM C - ABILITY AND LIMITATIONS FORM

NAME OF PARTICIPANT _____

ACTIVITY	<i>Activity permitted?</i>			COMMENTS
	YES No limita tions	YES With assist ance	NO	
This section is to be completed by a parent, guardian, caregiver, counselor, physician, physical therapist, occupational therapist or education/teacher who is familiar with the ability level and limitations of the participant				
WEIGHT BEARING ON FEET				
WEIGHT BEARING ON HANDS & KNEES				
WEIGHT BEARING STOMACH (PRONE)				
WEIGHT BEARING BACK (SUPINE)				
WEIGHT BEARING HANDS (i.e. handstand)				
HANGING/SWINGING FROM HANDS				
JUMPING/SPRINGING ON MATS				
JUMPING (BOUNCING) ON TRAMPOLINE				
BOUNCING ON SEAT - TRAMPOLINE				
ROLLING forward or backward over neck				
ROLLING longitudinal (i.e. -log rolling)				
OTHER				

- 1) If an assistant is recommended by the Club, who will be accompanying the participant?
 Name _____ Professional occupation (if applicable) _____
 Does the assistant represent an outside institution, agency or organization? NO ___ YES ___ If yes, please specify:

- 2) Person completing this form: _____ Date: _____

- 3) I feel that gymnastics would be beneficial for the applicant. The following limitations, if any, should be taken into consider when designing a program for this individual. (i.e. range of motion, special devices..)

- 4) The following is to be completed by a parent, guardian, caregiver, counselor, physician, physical therapist, occupational therapist or educator/teacher who is familiar with the ability level and limitations of the participant.
 In order to assist the Host Club in communicating effectively with the participant please complete the following:
 - a) Does the participant mind being touched? (i.e. spotting) Yes: _____ No: _____
 - b) Does the participant understand simple instructions? Yes: _____ No: _____
 - c) Does the participant need visual examples? (i.e. demonstrations) Yes: _____ No: _____
 - d) Is eye contact needed to effectively relay instructions? Yes: _____ No: _____
 - e) A gym is a noisy and busy place. How does the individual react/respond in this type of environment?

 - f) What is the most effective method to correct the individual's behaviour? (i.e. quiet time, stern voice, etc)

 - g) What are the symptoms to look for if the participant is confused, distressed, frightened or tired?

 - h) What are the most effective methods to comfort the individual?

 - i) What are the most effective methods to reward the participant?



Notice to all Downs Syndrome participants:

According to the Ontario Special Olympics, participation in gymnastics and similar activities by those individuals who have a positive gap greater than or equal to .5cm in the C1 and C2 vertebrae in the neck, could potentially result in "injury if they participate in activities that hyper-extend or radically flex the neck or upper spine." As a result of this recommendation, The Gymnastics Ontario requires all participants with Downs Syndrome, who are potentially predisposed to this condition, to be x-rayed, in order to determine whether or not this condition is present. Should the gap be greater than .5cm, for the safety of the individual, The Gymnastics Ontario prohibits participation by this individual in any gymnastic activity.

ATLANTO-AXIAL DISLOCATION EXAMINATION RESULT FORM

NOTE: ALL DOWNS SYNDROME APPLICANTS
MUST HAVE THE FOLLOWING SECTION COMPLETED BY THEIR DOCTOR

This is to certify that _____ who has Downs Syndrome, has had x-ray taken (full extension and flexion of the neck) to determine a pathological displacement of C1 and C2.

DATE OF X-RAY _____

RESULTS

Positive C1-C2 gap distance equal to or greater than .5

Negative C1-C2 gap distance less than .5

(Please circle) Positive/Negative & Indicate gap distance: _____ cm

Physician's Name _____ Phone _____

Signature _____ Date _____