MEMBERSHIP REGISTRATION PACK 2018

To be completed by all Athletes with Down syndrome competing in:

Gymnastics (Artistic & Rhythmic)
Trampoline

JUNE 2018

REGISTRATION APPLICATION FORM

CONFIDENTIAL

(Please print all information and complete in English)

Name:		Sport:	
General Information – complete the following from your Passport Information			Attach photo
Surname (Family Name)			
First Name (Given Name)			
Nationality			
Passport Number		Expiry Date *dd/mm/yyy* ...../...../.....	
Date of Birth *dd/mm/yyyy* ...../...../.....		Male ☐ Female ☐	
Diagnosis	**Down Syndrome Trisome 21 ☐ Mosaic Down Syndrome ☐**		
Atlanto Axial Instability (AAI) Yes ☐ No ☐		**Symptomatic AAI Yes ☐ No ☐**	
CONTACT INFORMATION (Mailing address)			
Address			
Tel: (inc Country Code)		**Mobile**	
Email			
PARENT/GUARDIAN DETAILS			
Name			
Address			
Tel: (inc Country Code)		**Mobile**	
Email			
Relationship			
Signature			
Date			

SU-DS REGISTRATION INITIAL FEE OF US$15 IS PAYABLE (see www.SU-DS.org for payment)

Team Managers are responsible for ensuring that they have sufficient medical insurance for travel out of their country of residence.
Please take proof of insurance with you when travelling.
Prescription medicine should be in marked prescription containers

NECESSARY EVIDENCE FOR THE CONFIRMATION OF DOWN SYDROME

- It is necessary for Registration to state clearly that the athlete has Down syndrome either:
  - Down syndrome Trisomy 21
  - Down syndrome Mosaic
- The most accurate way to provide this evidence is a blood test for Cytogenetic Analysis.
- If any other evidence is presented which in the opinion of our Medical Advisory Group is not conclusive, SU-DS retains the right to request the athlete to submit to a Cytogenetic Analysis. All evidence including the test for Cytogenetic Assessment is to be sent to SU-DS, who will make a decision regarding the status of the athlete. Any costs involved in the analysis are the responsibility of the athlete.

1. I …….. (state name) agree to participating in …….. sport and I am fully aware of the risks involved in this sport.
2. Should the status of my Down syndrome be questioned I agree to the administration of a blood test for Cytogenetic Analysis. (I understand I will be responsible for the cost of this)
3. In the event of Doping Tests being administered at any event I take part in, I agree to the giving of a sample for the purpose of Drug Testing.

Confidentiality of Information and/or Data Protection Statements

4. SUDS complies with the European General Data Protection Regulations.
   a. As Registered athletes with SUDS your records are kept electronically.
   b. You can access this information to request SUDS to correct or update information.
   c. SUDS does not release your information to anyone involved in direct marketing.
   d. Personal information such as your medical information and your address is never shared outside that of the SUDS Executive Board and then only to confirm your Down syndrome status.
5. I agree to this information being shared with event organisers and only where necessary for the sport.

ATHLETE SIGNATURE: …… DATE: ……..

Signed in the presence of ……..(name) DATE: ……..

Signature: ……

Relationship to the Athlete ……..

(For more Information about Doping and Data protection refer to Page 7 of the GUIDELINES for this Form)

INFORMATION FROM THE ATHLETE'S MEDICAL PRACTITIONER

MEDICAL CONFIRMATION OF DOWN SYNDROME

Name of Athlete: …… Date of Birth:……..

I can confirm the Down syndrome condition of this athletes as:

Down syndrome Trisome 21 [ ] Trisomy 21 Mosaic [ ]

NOTE:
The preferred analysis is a conventional cytogenetic analysis to confirm whether there are 2 cell lines and it is trisomy 21 or trisomy 21 mosaic

Details of the Analysis used ……..
(A copy of the document giving confirmation of Down syndrome MUST be attached)

Surgery/Hospital Stamp

Signed: …… Date: …….

Name: ……

Does the gymnast have appropriate physical health to participate? Yes ☐ No ☐

Restrictions ……

……

Does he/she take any medication? Yes ☐ No ☐ In case of Yes, which?

Substance (Generic)	Administration Dose	Route of Administration	Frequency of Administration
Intended Duration of treatment (Please tick appropriate box)		Once only [ ] Emergency [ ] Duration (week/month) ……	

1. Does he/she have any medication allergy? Yes ☐ No ☐ In case of Yes, which?

.....

2. Does he/she have any food allergy? Yes ☐ No ☐ In case of Yes, which?

.....

3. Does he/she have any food intolerance? Yes ☐ No ☐ In case of Yes, which?

.....

4. Health care: Allergies ☐ Asthma ☐ Skin ☐ Epilepsy ☐ Lung ☐

7. Surgery.....

8. Any special care: .....

9. Vaccines: Tetanus ...../...../.....; Hepatitis ...../...../.....

SCREENING for ATLANTO AXIAL INSTABILITY (AAI)

Clearance of AAI may be made by attaching relevant Medical Letters , OR:
A qualified medical practitioner must complete the following tests and questions.

Please refer to the Guidance Notes – page 3

1. Does the person have good head / neck muscular control? Yes ☐ No ☐
2. Does the person's neck flexion allow the chin to rest on the chest? Yes ☐ No ☐

If an ATHLETE has a NEGATIVE test on any of the above, THEY WILL NOT BE ABLE TO take part in some of the Sport's activities (for more information consult the appropriate Organisation)

On completion of the screening, one copy of the fully completed approval form must be attached to this registration form. The coach should keep a second copy on file for their reference.

DOCTOR /CONSULTANT contact information: MAILING ADDRESS

Name			Doctors Surgery Stamp ESSENTIAL
Medical Specialty			
Address:			
Country and Post Code		Phone (inc Country Code)	

Signed		Date	

DECLARATION OF MEDICAL CONDITIONS THAT MAY REQUIRE EMERGENCY MEASURES

[please print all information and complete in English]

Athlete's Name …… Date of Birth ……..

I understand that SU-DS requires me to state any known medical conditions that may compromise my safety in my sport. I understand that I must state the current management for my condition[s] ***(please print n/a if there are no associated medical conditions)***

I have the following medical condition(s)

_____

_____

The current management for the above is

_____

_____

I understand that if I fail to state any known medical conditions and if this condition results in having to perform a rescue, I will automatically be deemed ineligible for the competition. I also understand that if a condition becomes evident for the first time during competition and is diagnosed at the time e.g. dehydration, I will still be eligible to compete as long as I observe the recommended management for the condition.

SIGNATURE OF DOCTOR / CONSULTANT…….. Date…….

Surgery Stamp

SIGNATURE OF GYMNAST ……

SIGNATURE of PARENT/GUARDIAN/WARD [UNDER AGE 18]:

……

Name…….

RELATIONSHIP ……DATE …….

This form is to be resubmitted if there are changes to the condition and medication and/or management.

Please return complete Form with all associated parts to SU-DS at

SU-DS
11 High Beech
Coventry CV5 7QD

U.K.

Papers may also be sent as scanned documents or as .pdf files to:

CEO@SU-DS.org

EXEMPTIONS

Certain physiological conditions may prevent a gymnast from performing some moves correctly in accordance with FIG Rules.

This Form is to be used to document those conditions for an assessment by the DSIGO Medical Officer and Technical Staff to allow for Exemptions to be authorized from the FIG Rules. These Exceptions will be subject to review by the DSIGO Medical and Technical Director during competition.

This Form must be submitted not less than every two (2) years for a review of the conditions.

Gymnast's Name: …….. Date of Birth …….

DECLARATION

The above named gymnast has the following physiological conditions which impact upon his/her ability to perform some gymnastic moves according to the FIG Rules.
(Please provide an outline diagnosis of the physical impairments/condition with an estimate of the physical effect on gymnastic moves.)

……

……

……

……

Name: ……Designation ……

Address: ……

……

……

Surgery Stamp

Signature…… Date ……

Please attach to the Registration Form details of medical diagnosis and physical or functional conditions for the assessment of the DSISO Medical Officer.

NOTE: It is the responsibility of the Gymnast (or Parent/guardian) to ensure that this information is reviewed every two years and the Review sent to SU-DS for dissemination to DSIGO. If no Review is submitted it will be assumed that the Exemptions are no longer necessary

Continue on a separate page if necessary