# FORMS FOR DUPLICATION

*Important: Be sure to make multiple copies of these forms for continued use.*

**FINANCE**



**INSURANCE**



**SPORTS**



**FUNDRAISING**

# In-Kind Contribution Receipt

In-kind contributions are services and materials donated in place of cash contributions. In-kind contributions are recorded at fair market value. Fair market value should be established on an objective and clearly measurable basis, i.e., normal rent charge for a facility, advertised costs for equipment and the posted price for food or beverage.

**Date of Contribution:** ____/____/____

The information below is required for internal recordkeeping. Per IRS guidelines, Special Olympics Wisconsin is prohibited from establishing monetary values for gifts of real or personal property or stating a value on donor receipts for gifts in-kind. Should you have questions, refer to www.irs.gov publications 526 & 561, and consult your tax advisor. Please retain a copy of this form for your records.

**Contributor**

Name: _____

Business/Organization: _____

Address: _____

City, State, Zip: _____

Phone: _____

Email: _____

| Item/Service | Qty | Unit Price | Total Estimated Value (Provided by Contributor) |
|---|---|---|---|
| | | $ | $ |
| | | $ | $ |
| | | $ | $ |
| | | $ | $ |
| | | GRAND TOTAL: | $ |

**Signature of Contributor:** _____ **(required)**

To be completed by Special Olympics Wisconsin Representative

**Purpose of Contribution**: _____

SOWI Staff or Agency Manager: _____

Signature Print Name Date

**In-Kind to be used by (check one):**

☐ **Headquarters** ☐ **Region #** ____ ☐ **Agency #** ____

**Fund #: 4009-**____

**Appeal:**____

**Package:** ____

**Soft Cr:** ____

**Event Cr:** n/a

**Ref:** ____

**Account #:** ____

**Reference:** ____

**Return to:** **Special Olympics Wisconsin** **(Specific return address)**

_____

_____

_____

# Special Olympics Wisconsin
# Manual Receipt Form

Name of Payee: _____ Agency Number: _____

Amount: _____ Agency Manager Approval: _____

Purpose (be specific): _____ Expense Code: _____

: _____ Date Paid: _____

Why is original receipt missing?: _____ Check Number: _____

_____ Date of Purchase: _____

Name of Payee: _____ Agency Number: _____

Amount: _____ Agency Manager Approval: _____

Purpose (be specific): _____ Expense Code: _____

: _____ Date Paid: _____

Why is original receipt missing?: _____ Check Number: _____

_____ Date of Purchase: _____

****Please note: This form requires an Agency Manager signature for approval.**

Special Olympics Wisconsin

# Invoice Approval Form

Name of Payee: _____

Amount: _____

Agency Number: _____

Agency Manager Approval Signature:

_____

_____
Print name

Purpose (be specific – tell who, what, where, when and why):

_____

_____

_____

_____

_____

*Witness Approval Signature:

_____

_____
Print name

***MUST be signed by member of Agency Management Team who is a Class A volunteer without financial restrictions and is not a family member of the manager**

Expense Code: _____

Date to be Paid by: _____

Date of Purchase: _____

***Please Note: This form requires an Agency Manager signature for approval.**

## Agency In-House Petty Cash Request

Agency Number _____

Agency Name _____

Petty Cash Amount Requested $_____

Petty Cash for: (Please check one) ☐ Agency Fund or ☐ Special Event

If Special Event: Name of Special Event _____

Date Needed _____

Designated Class A Volunteer _____

This is the person who will be responsible for the petty cash and should have no financial restrictions. The check will be made out in this persons name.

Address to send check to _____

Approval Signature _____

Agency Manager Signature

Approval Signature _____

Class A Volunteer Signature

# Petty Cash Ledger

**Agency Number/Name:**

| Date | Who | Amount | Where | Purpose | Expense Code |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

# AGENCY DEPOSIT TICKET

Use this form to submit deposits to the Program Office.

If deposit includes taxable items such as Admissions, Auction, Concessions, Games & Entertainment or Souvenirs) attach Sales Tax Summary form.

| | | |
|---|---|---|
| | | All deposit forms can be found under "Agency Forms & Tools" on our website: www.specialolympicswisconsin.org/agency<br><br>Contact the Program Office if you need assistance logging in. |
| **Date** | | |
| **Deposit Total** | | |
| **Total Items for Deposit** | | |
| **Agency #** | | |
| **Agency Name** | | |
| **Submitted by** | | |
| **Email Address** | | |
| | | |

| | |
|---|---|
| **Attachments:** | ☐ Sales Tax Summary Form<br>☐ Bank Deposit Receipt(s) |
| | (For cash deposits made at Johnson Bank. List breakouts - Amount, Account Number & Reference in comments section below) |

**Comments:**

## AGENCY DEPOSIT LEDGER TEMPLATE

-Use this form to keep an in-house agency record of the deposit.

| Date | First | Last | Org/Bus Name | Address | City | State | Zip | Phone | Check # | Amt | Acct # | Ref |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | **Total** | | | | | | | | | | | |

# SALES TAX REPORTING FORM

- Use this form to track taxable items sold at fundraisers and special events.
- Submit completed form with deposit. Taxable items on form must match taxable items in deposit
  Revenue must be deposited in the month items were sold.

Special Olympics Wisconsin

| | |
|---|---|
| **Sales Date:** | |
| **Submitted by:** | |
| **Sales Event Name:** | |
| **Sales Event County:** | |
| **Comments:** | |
| | |

| **Item Description** | **Sales Tax Category**: Admissions, Auction, Concessions, Games & Entertainment or Souvenirs) | **Unit Price x** | **Quantity Sold** | **= Sales Total** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| **Total** | | | | **$** |

**I verify the accuracy and completeness of information listed above:**

**Signature** **Date**

2310 Crossroads Drive, Suite 1000
Madison, WI 53718
(608) 222-1324
(800) 552-1324 (toll-free)
(608) 222-3578 (fax)

# Money Handling ACCOUNTABILITY

The following procedures will occur at all SOWI fundraising events:

1. At least two people will count money and both individuals will sign off on the counts in order to be held accountable.
   a. These individuals will be Class A volunteers with no financial restrictions
   b. These individuals will not be related to each other.
2. This completed form will be forwarded to the Headquarters office with the deposit information.

Event:_____

Date:_____

Region:_____

Total Cash:_____

Total Checks:_____

Total Credit Card:_____

Total Collected:_____

_____ _____
Signature Printed Name

_____ _____
Signature Printed Name

Mutual Respect, Positive Attitude, Accountability, Teamwork and Dedication
Values SOWI lives by to create an environment of integrity where winning is more than coming in first.

*Created by the Joseph P. Kennedy Jr. Foundation for the benefit of individuals with intellectual disabilities. Authorized and Accredited by Special Olympics, Inc.*

**Special Olympics Wisconsin, Inc**
**Volunteer Expense Reimbursement Form**

**Agency Number: _____**

**Name: _____**

**Address: _____**

**Mileage Reimbursement:**

| Date | Trip/Purpose Explanation | Number of Miles | Allowance (miles x .14) | Account/ Cost Center |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| **Totals** | | | | |

**Other Travel Reimbursement:**

| Date | Trip/Purpose Explanation | Airfare | Room | Meals | Car Rental/Cab | Account/ Cost Center |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| **Totals** | | | | | | |

- Original receipts must be attached

**Miscellaneous Expense Reimbursement:**

| Date | Purpose Explanation | Items to be Reimbursed | Amount | Account/Cost Center |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| **Totals** | | | | |

- Original receipts must be attached

**Approval: _____ Grand Total: _____**
**Agency Manager**

**Approval: _____ Date: _____**
**Class A Volunteer**

WISCONSIN DEPARTMENT OF REVENUE
2135 RIMROCK RD
PO BOX 8949
MADISON, WI 53708-8949

**State of Wisconsin** • DEPARTMENT OF REVENUE

2135 RIMROCK RD PO BOX 8949 MADISON,WI 53708-8949
PHONE: 608-266-2776 FAX: 608-267-1030 TTY: 608-267-1049
EMAIL: sales10@dor.state.wi.us WEBSITE: www.revenue.wi.gov

April 14, 2011
Letter ID: L1060708032
Batch Index: 1160464896-466

SPECIAL OLYMPICS WISCONSIN INC
2310 CROSSROADS DR STE 1000
MADISON WI 53718-7600

This is your Wisconsin Sales and Use Tax Certificate of Exempt Status (CES). Purchases made by your organization or entity are taxable unless you provide a properly completed Wisconsin Sales and Use Tax Exemption Certificate (Form S-211), listing the CES number shown below, to your supplier(s).

If your organization makes sales, they may be subject to sales tax collection and you may be required to obtain a Seller's Permit. Information regarding registration requirements can be found in our Publication 206, Sales Tax Exemption for Nonprofit Organizations.

Forms and Publications can be obtained through our web site at www.revenue.wi.gov or through our forms ordering line at (608) 266-1961. Many questions can be answered by reviewing the FAQ pages on our web site. You may also contact us by telephone at (608) 266-2776 or by email at sales10@revenue.wi.gov.

## WISCONSIN SALES AND USE TAX CERTIFICATE OF EXEMPT STATUS (CES)

**(Governmental, Religious, Charitable, Scientific or Educational Organization)**

Sales to this organization or entity are exempt from Wisconsin sales and use tax under sec. 77.54(9a) and 77.55(1), Wis. Stats.

This certificate is valid unless cancelled by the Wisconsin Department of Revenue.

SPECIAL OLYMPICS WISCONSIN INC
2310 CROSSROADS DR STE 1000
MADISON WI 53718-7600

| CES NUMBER |
| --- |
| 012517 |
| DATE ISSUED |
| 12/18/1973 |

IMPORTANT:

Purchases made by your organization are taxable unless you furnish your supplier with the CES number shown above.
Sales by your organization may be subject to tax. If your organization makes taxable sales, it may be required to obtain a seller's permit and remit sales tax to the Department of Revenue.

Questions: Contact the Department of Revenue by telephone at (608) 266-2776, FAX (608) 267-1030, E-mail sales10@revenue.wi.gov, or at our Web site www.revenue.wi.gov

WINPAS - atL015 (R.01/08)

# Agency to Agency Funds Transfer

| | |
|---|---|
| Agency Holding Event (To:) | |
| Event | |
| Date | |
| Reason for transfers: | |

***By signing this form on behalf of my Agency, I authorize the transfer of funds to cover this event.***

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| (From:) | | | | | | **Class A Volunteer** | |
| **Agency Number** | **Agency Name** | **Item** | **Number of Items** | **Cost Per Item** | **Total Cost** | **Print Name** | **Signature** |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

Special Olympics Wisconsin

# Investment Options for Agencies

# Account /Amount Designation Form

**Date** _____

**Agency Number** _____

**Agency Name** _____

**Deposit $ _____ into the Special Olympics Money Market Savings Account**

**Deposit $ _____ into the Special Olympics 1year Certificate of Deposit.**

**Agency Manager Signature & date 1** _____

**Class A volunteer Signature & date 1** _____

Mutual Respect, Positive Attitude, Accountability, Teamwork and Dedication—Values SOWI lives by to create an environment of integrity where winning is more than coming in first.

Special Olympics Wisconsin

## Investment Options for Agencies

## Transfer Form

**Use this form when you wish to transfer money between accounts for your Agency.**

**This transfer will be made on the 1st business day of the month.**

**Date** _____

**Agency Number** _____

**Agency Name** _____

**Choose One:**

☐ **Transfer $ _____ from my Agency savings account to my Agency checking account.**

☐ **Transfer $ _____ from my Agency checking account to my Agency savings account.**

**Agency Manager Signature 2** _____

**Class A volunteer Signature 2** _____

Mutual Respect, Positive Attitude, Accountability, Teamwork and Dedication—Values SOWI lives by to create an environment of integrity where winning is more than coming in first.

Special Olympics Wisconsin

# On-line Order Form

Please go on-line and locate the item you wish to purchase.

| | |
|---|---|
| **What is the website address:** | |
| **What is the item number:** | |
| **What is the model number:** | |
| **Description of the item / color:** | |
| **What is the cost:** | |
| **How many would you like to order:** | |
| **Address to ship order to?** | |
| **E-mail address:** | |
| **Phone Number:** | |

---

| **Invoice Approval** | |
|---|---|
| **Agency Number:** | |
| **Agency Name:** | |
| **Purpose (be specific – tell who, what, where, When and why)** | |
| **Expense Code:** | |

**Agency Manager Approval: _____**
**Date:_____**

**Witness Approval: _____**
**Date:_____**

# SPECIAL OLYMPICS
## FIRST REPORT OF ACCIDENT / INCIDENT

**U.S. PROGRAM/AREA:** _____ **Date of Incident:** _____

**INJURED PARTY:**
☐ Athlete
☐ Volunteer
☐ Coach
☐ Employee
☐ Spectator
☐ Unified Partner
☐ Property Owner
☐ Other: _____

**Injured Person/Party Information** Date of Birth: ____/____/____ Age: _____

Name: _____
(Last) (First) (MI)

Address: _____
(Street) (City) (State) (Zip)

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Gender: ☐ Male ☐ Female Social Security Number: _____-____-_____

**TYPE OF INJURY/ ACCIDENT:**
☐ Bodily Injury
☐ Property Damage
☐ Automobile
☐ Other: _____

**Description of Accident** (If automobile accident occurred, please attach a copy of the police report).

Describe how the accident occurred (Attach a separate sheet if necessary): _____
_____
_____
_____

Site / event where accident occurred: _____

**ACCIDENT OCCURRED DURING:**
☐ Training/Practice
☐ Competition
☐ Traveling to or from SO event
☐ Other: _____

**TYPE OF INJURY:**
☐ Severe cut w/ bleeding
☐ Less serious bruise or cut
☐ Break/fracture
☐ Concussion
☐ Paralysis
☐ Fatality
☐ Other: _____

**DISPOSITION:**
☐ Released to parent
☐ Refusal of care
☐ Refer to doctor
☐ Refer to hospital or clinic
☐ Medical attention
☐ EMS transport
☐ Patient requested EMS transport
☐ Released to personal vehicle
☐ Police
☐ Ambulance
☐ Report only
☐ Other: _____

**SPORT**
☐ Alpine Skiing
☐ Aquatics
☐ Athletics
☐ Badminton
☐ Baseball
☐ Basketball
☐ Bocce
☐ Bowling
☐ Cheerleading
☐ Cross Country Ski
☐ Cycling
☐ Equestrian
☐ Figure Skating
☐ Floor Hockey
☐ Golf
☐ Gymnastics
☐ Kickball
☐ Power Lifting
☐ Relay Game
☐ Roller Skating
☐ Sailing
☐ Snowboarding
☐ Snowshoe
☐ Soccer
☐ Softball
☐ Speed Skating
☐ Swimming
☐ Table Tennis
☐ Team Handball
☐ Tennis
☐ Track & Field
☐ Volleyball
☐ Other: _____

**BODY PART INJURED:**
☐ Head
☐ Neck
☐ Torso
☐ Back
☐ Hand (L / R)
☐ Finger (L / R)
☐ Elbow (L / R)
☐ Shoulder (L / R)
☐ Leg (L / R)
☐ Knee (L / R)
☐ Thigh (L / R)
☐ Shin (L / R)
☐ Toe (L / R)
☐ Other: _____

**Contact/Care Provider Information** If an athlete or underage volunteer was injured, please identify the care provider and/or responsible party (e.g. parent, legal guardian).

Relationship to the injured person: _____
Name: _____
Address: _____
_____
Home Phone: (_____) _____-_____

Employer Name: _____
Employer Address: _____
_____
Work Phone: (_____) _____-_____

Does the injured person have medical insurance? ☐ Yes ☐ No
If yes, insurance is provided by: ☐ Injured Person ☐ Care Provider/Responsible Party
Please provide name of Company and Policy Number: _____

**Witness Information** (Please provide names and phone numbers of any witnesses to the incident)

Witness #1 Name: _____ Daytime Phone: (_____) _____-_____
Witness #2 Name: _____ Daytime Phone: (_____) _____-_____

**Special Olympics Official / Representative** (other than claimant)

Name: _____ Daytime Phone: (_____) _____-_____
Signature: _____

**SEND COMPLETED FORM TO:**
AMERICAN SPECIALTY INSURANCE & RISK SERVICES, INC.
7609 W. Jefferson Blvd., Suite 150
Fort Wayne, Indiana 46804-4133 | Fax: 260.969.4729

**IF INJURY WAS SERIOUS OR A FATALITY:**
IMMEDIATELY NOTIFY AMERICAN SPECIALTY
AT 800.566.7941, 24 hours a day/7 days a week

# SPECIAL OLYMPICS
# REQUEST FOR CERTIFICATE OF INSURANCE

*(This form is only utilized when a facility/organization requires a certificate of insurance.)*

1) Date: _____ Person Completing this Form: _____

2) U.S. Program/Area: _____

3) U.S. Program/Area Address: _____

4) U.S. Program/Area Phone No: _____ Fax _____

E-mail _____

5) Name of Event: _____ Date(s) of Event: _____

6) Site or Location of Event: _____

7) Is Event a Fundraising Activity? ☐ YES ☐ NO If the event is a Fundraising Activity, please provide answers to the following:

a. Will the event last more than 7 consecutive days? ☐ YES ☐ NO

b. Will more than 5,000 spectators/participants be in attendance of the event? ☐ YES ☐ NO

c. Are participants required to sign a Release of Liability Waiver? ☐ YES ☐ NO

***Please attach any pertinent information regarding fundraising activities (brochure, advertisement, specific details)***

Note: If the event involves any of the following, please contact Jina Doyle at jdoyle@amerspec.com or (260)673-1127 immediately, as the policy either specifically **EXCLUDES** coverage for these events or requires the U.S. Program to meet certain underwriting requirements. Coverage is not provided for the following activities unless approved in advance by the Insurer.

- Alcohol
- Rock Climbing Walls
- Aircraft (other than a Plane Pull)
- Animals (other than Equestrian practices/competitions)
- Firearms
- Fundraising Events lasting more than 7 consecutive days
- Inflatable Devices
- Mechanical Rides
- Golf Ball Drops
- Fireworks
- Rodeos
- Fundraising Events with more than 5,000 people (including spectators and participants) in attendance

8) Is Event Exclusively for Special Olympics Athletes? ☐ YES ☐ NO

9) Is Event Sponsored by a Special Olympics Program? ☐ YES ☐ NO

10) Is the Event Conducted by a Special Olympics Program? ☐ YES ☐ NO

11) Is Alcohol Being Served at the Event? ☐ YES ☐ NO

If so, please provide additional details (such as alcohol is included in ticket price, cash bar, donated): _____

12) Certificate Holder (entity requiring certificate): _____

13) Does the Certificate Holder require Additional Insured status*? ☐YES ☐NO

a. If so, please outline the requested Additional Insured wording: _____

b. If so, please outline the Additional Insured's role in the event (such as sponsor, location of event, etc. _____

_____

14) Certificate Holder Contact Person: _____

15) Certificate Holder Address: _____

16) Certificate Holder Phone No.: _____ Fax: _____

E-mail: _____

***ADDITIONAL INSURED STATUS SHOULD BE CHECKED ONLY IF IT IS A REQUIREMENT OF THE CERTIFICATE HOLDER.**

17) Are you required to enter into an agreement/contract/permit with another party relative to the above-referenced event that contains assumption of liability, indemnification, or hold harmless language? ☐ YES ☐ NO
**If so, please send a copy of the contract with the Certificate Request Form.**

Original Certificate should be sent to: ☐ Certificate Holder ☐ U.S. Program

**SEND TO:**
**ATTN: RENE WATERSON E-MAIL: rwaterson@amerspec.com**
**AMERICAN SPECIALTY INSURANCE & RISK SERVICES, INC.**
**P.O. BOX 309**
**ROANOKE, IN 46783-0309 TELEPHONE: (800) 245-2744 FAX: (260) 672-8835**

# Special Olympics Wisconsin
# Contract Review Checklist

**Purpose of Checklist**

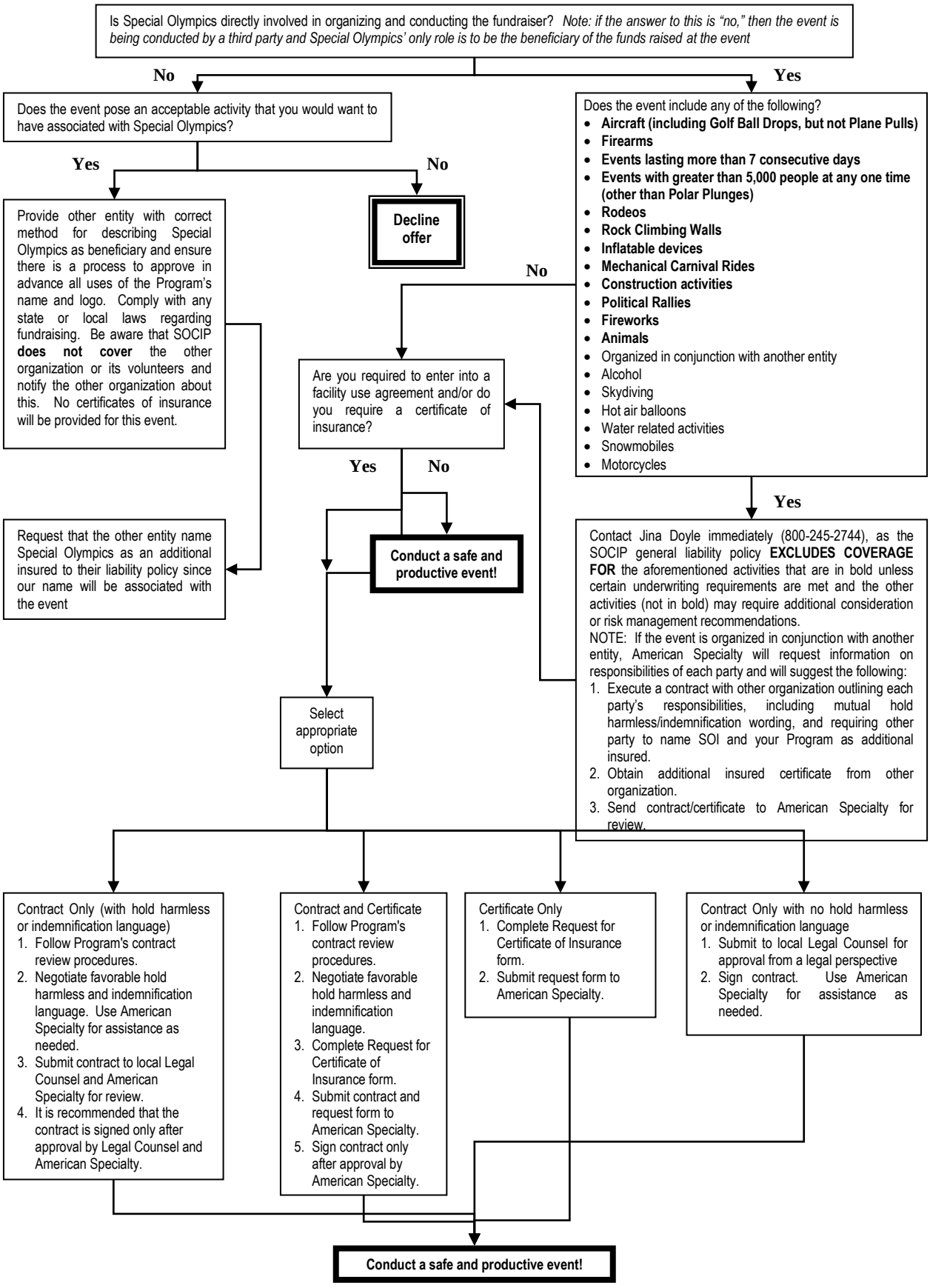
The following checklist is provided as a tool to help Special Olympics U.S. Programs when determining whether to sign a contract/agreement with a venue or facility. This checklist focuses on risk management issues and applies primarily to facility or venue use agreements/contracts. Although some of the same principles may apply, this checklist is not intended to be used for contracts such as hotel agreements, sponsorship agreements, long-term building leases, etc. A U.S. Program should always follow its own protocol relative to the contract review process and should work with legal counsel and insurance representatives (American Specialty or local broker) as appropriate.

**Using the Checklist**

If the answer to any of the questions below is "no," separate action is recommended prior to signing. Also, please utilize the Event Flowchart to help identify any additional steps that may need to be taken relative to insurance.

| | |
|---|---|
| ☐Yes ☐No | Do you have a complete, legible copy of the contract? |
| ☐Yes ☐No | Are all parties listed by their formal legal names? |
| ☐Yes ☐No | Are the effective dates and times of the agreement accurately stated? |
| ☐Yes ☐No | Are the individuals to sign the agreement authorized representatives of each party? |
| ☐Yes ☐No | Is the indemnification and hold harmless provision "acceptable"?<br>**Acceptable:**<br>• Other party indemnifies and holds Program harmless for losses, and Program doesn't indemnify or hold other party harmless; or<br>• Each party is responsible for its own negligence - mutual indemnification and hold harmless; or<br>• Program indemnifies and holds other party harmless **but not** for losses arising from other party's negligence (or other party's sole or gross negligence). This is acceptable although above options are preferable.<br>**Not Acceptable**<br>• Program indemnifies other party and holds them harmless for any and all losses (including those arising from other party's own negligence), and other party doesn't indemnify or hold Program harmless. |
| ☐Yes ☐No | Does the Program carry the insurance coverage required in the contract? |
| ☐Yes ☐No | Is the additional insured requirement consistent with the indemnification and hold harmless provision?<br>For example:<br>• If there is mutual hold harmless and indemnification, the parties should name each other as additional insured.<br>• If the Program must hold harmless and indemnify the other party for losses arising out of the Program's negligence only, then the Program should be required to name the other entity as an additional insured only with respect to losses arising out of the Program's negligence. |
| ☐Yes ☐No | Are the cancellation requirements acceptable (for example, they do not place an undue financial burden on the Program if the Program needs to cancel)? |

# Insurance Needs Fundraising Event Flowchart



# SPECIAL NEEDS ATHLETE FORM

**Completed Special Needs Forms can be copied, but must be submitted at the registration deadline for ALL levels of competition.**

Coaches who have athletes with special needs (i.e. communication limitation, hearing or visual impairment, special equipment adaptations or behavioral needs) can relay important information to the event volunteer as to how to best work with the athlete. In some cases, a coach may be allowed to be in the competition area for consultation with the volunteer(s) working with the athlete. It is important in this situation for the coach to introduce the athlete to the volunteer(s) and advise the volunteer(s) on how to work with the athlete. The coach will not be allowed to remain in competition area. **Special needs forms are intended to be an aid for the volunteer in working with the athlete and are not to be used for performance-related instructions or coaching tips.**

If you have a "Special Needs" athlete please complete the following form (one per athlete). If necessary, this information will be included on the event card. If you do not complete this form, it may be more difficult to accommodate the "Special Needs" for your athlete.

| |
|---|
| Athlete Name: |
| Agency Number and Name: |
| Coach Name: |

☐ **REQUEST Day of Event Venue Volunteer**
- Must obtain prior approval from Event Director (not all requests can be approved).
- Check reason(s) and provide a brief explanation below

☐ **REQUEST 1:1 Agency Volunteer** – check reason(s) or provide a brief explanation below

☐ **REQUEST 1:1 State Games Housing Chaperone** (non-competition related) – provide a brief explanation below
**1:1 Class A Chaperone Name:** _____(must match your Coach/Chaperone Roster)

| **General Special Needs:** (check all that apply) | | | |
|---|---|---|---|
| ☐ | Guide to/from event/start | ☐ | Non Verbal |
| ☐ | Behavior issues | ☐ | Hearing Impaired |
| ☐ | Wanders | ☐ | Visually Impaired |
| ☐ | Unsteady on feet | ☐ | Seizures |
| ☐ | Special Equipment – explain below: | ☐ | Medical condition that may require the administration or consumption of medication, food or liquids during competition. – provide a brief explanation below. |
| ☐ | Other – explain below: | | |

**Explanation:** (Please be as brief as possible):

_____

_____

_____

Special Olympics Wisconsin

# ATHLETE MEDICAL INFORMATION

**Agency:** _____ **Coach:** _____
**Athlete Name:** _____ **Sex:** ☐ **M** ☐ **F**
**Address:** _____
_____
**Date of Birth:** _____ **S.S. #:** _____
**Doctor:** _____ **Phone:** _____
**Specialty** _____
**Doctor:** _____ **Phone:** _____
**Specialty** _____

**EMERGENCY CONTACTS**
**1) Name:** _____ **Phone:** _____
**Address:** _____
**2) Name:** _____ **Phone:** _____
**Address:** _____
**Able to Make Own Medical Decisions** ☐**Y** / ☐**N**

**MEDICAL INSURANCE**
**Company Name:** _____
**Policy Number:** _____
**Company Name:** _____
**Policy Number:** _____

**GENERAL HEALTH INFORMATION**
_____
_____
_____
_____
_____
**Pain Tolerance:** ☐ **Low** ☐ **Normal** ☐ **High**
**Last Tetanus Shot** _____
**If applicable:**
**Last Influenza Shot** _____ **Last Pneumococcal Shot** _____
**MEDICAL DATA AS OF: Month** _____ **Year** _____

**MEDICAL HISTORY (Check all that exist)**
☐ **No known medical conditions**
☐ **Asthma**
☐ **Diabetes**
☐ **Seizure Disorder**
☐ **Hypertension**
☐ **Coronary Artery Disease**
☐ **Bleeding/Clotting Disorder**
☐ **Stroke**
☐ **Hearing Impaired**☐
☐ **Pacemaker**
☐ **Sickle Cell Anemia**
☐ **Dementia**
**Vision Impaired**
**Other/Details** _____
_____
_____
_____
_____

**ALLERGIES (Please describe reaction)**
☐ **No known allergies** ☐ **Environmental**
☐ **Insect Stings** ☐ **Latex** ☐ **Aspirin**
☐ **Ibuprofen** ☐ **Tylenol** ☐ **Penicillin**
**Other Allergies** _____
_____
**Reaction Description(s)** _____
_____
_____
_____

**MEDICATIONS**

| Name | Dose | Frequency | Indication |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Athlete Medical Information Instructions**

The following are additional questions/clarification to assist you in providing the most accurate and relevant medical information to Special Olympics-WI coaches and medical staff, in addition to emergency medical personnel, if needed. Please feel to provide sensitive information via other methods.

**Emergency Contact**

Is the athlete able to make own medical decisions?

If no, please indicate on form and list who is able to make such decisions, i.e. guardian/Power of Attorney for Healthcare, as Emergency Contact #1.

**General Health Information:** Please see below and the back of this sheet for a list of questions.

**Medical History:** Please check/list all current medical problems, major surgery/illness, and medical conditions that may alter evaluation or treatment. In addition, please see below and back side of this sheet for questions about certain conditions.

**Allergies:** Please check/list any allergies (medication, food, latex, other). Include type of reaction [Anaphylactic (trouble breathing, throat swelling), rash, GI problems, other]

**Medications:** Please list all medications, vitamins and supplements taken. In addition, list any recent medication changes and medication side effects that need to be watched for (sun sensitivity, dehydration, etc) in the General Health Information Section. Also, please include if and what over-the-counter medications the athlete may have **for minor pain, etc.**

---

**General Medical Information Questions:** Please indicate answers in the General Health Information or Medical History Sections (only need to provide information if answer is different than "normal")

General Information

- Is the athlete unable to answer the following?
  - Date, Place, Date of Birth
- Does the athlete have any significant weakness, paralysis, decreased sensation, deformity, spasticity, or rigidity?
- Does the athlete have any hearing, eye or vision problems, especially unequal pupils?
  - Any communicative disabilities?
- Does the athlete have any chronic skin conditions?
- Any "missed" immunizations?
- Any significant family history (heart disease, diabetes, cancer)?
- Any medical dietary restrictions? Please indicate reason for restriction.

Female Specific

- Does the athlete have heavy menstrual bleeding or cramping?
- Does she know her menstrual cycle?
- Any possibility of pregnancy?

Behavioral/Disability Conditions

- Does the athlete need assistance with personal cares, meals, daily activities, etc.?
- Any behavioral problems or psychiatric diagnoses?
  - Triggers? Interventions? Medications?

Heart/Lung Conditions

- Does the athlete have a heart or lung condition that places them at higher risk of illness or injury? [determined by a physician]
- Does the athlete have high blood pressure, irregular heart rhythm, heart murmur, or bleeding problems?
  - Do they take medication?

Gastrointestinal Conditions

- Does the athlete have chronic over/under eating, heartburn, constipation, diarrhea, or abdominal pain?
  - Medication?
  - Treatment (foods to avoid, etc)

Headaches/Migraines

- Does the athlete often get headaches/migraines?
- How severe are they?
  - Complications: vomiting, visual changes, etc?
- How long do they last?
- What treatment is most effective?

Urinary Conditions

- Does the athlete have frequent urinary tract/bladder infections?
  - Signs/Symptoms?
  - Frequency of infections?
  - Usual Medication (antibiotic prescribed by a physician)

---

Specific Medical Condition Questions

Seizures

- Are they true seizures, pseudo-seizures, fake/behavioral seizures?
- Please describe in detail a typical seizure, including frequency, duration, body movements, staring, post-seizure recovery behavior/duration, reasons for going to the emergency department.
- Recent medication changes?

Diabetes

- Do they have a glucometer? Are they able to check their own blood sugar? How often do they check their blood sugar levels?
- Is there any medication that needs to be adjusted for missed meals or increased activity? If so, which medications and how?
- Do they often have episodes of low blood sugar?

Asthma

- Do they have asthma?
- Triggers?
- How severe is their asthma?
  - How often do they have an attack?
  - How severe is their attack?
  - Recent ED visits/hospitalizations?

    History of ICU visits/intubations?

# MOTOR ACTIVITIES TRAINING PROGRAM (MATP)
# SANCTION FORM

This form must be completely filled out and submitted to the Program office at least eight weeks prior to the scheduled training day activity. Challenge award ribbons will be mailed out to MATP programs two weeks prior to the event.

*PLEASE PRINT OR TYPE*

MATP Coordinator: _____

Phone: Daytime: _____ Evening: _____

E-mail Address: _____

Agency: _____

Address: _____

City: _____ State: _____ Zip: _____

Estimated number of MATP Special Olympics athletes participating: _____

Estimated coach-to-athlete ratio: _____

Training Dates: _____

Training Site: _____
(Location) (City)

Training Day Activity Site (if different): _____
(Location) (City)

Mail eight weeks prior to training day activity to:

**Special Olympics Wisconsin**
**2310 Crossroads Dr. Ste. 1000**
**Madison, WI 53718**
**Attn: Director of Training and Competition**

**MOTOR ACTIVITIES TRAINING PROGRAM (MATP)**

The Special Olympics Motor Activities Training Program (MATP) is designed for persons with the most severe handicaps who do not yet possess the physical and/or behavioral skills necessary to participate in Official Special Olympics Sports. The program provides a comprehensive motor activity and recreation training curriculum for these participants that can be administered by a variety of trainers (e.g., physical educators, re-creators, and therapists). In addition, direct care workers, parents, and volunteers will find the MATP helpful in developing appropriate motor programs for individuals with severe handicaps.

The Motor Activities Training Program emphasizes training and participation rather than competition. The MATP utilizes goals, short term objectives, task analyzed activities, assessments, and teaching suggestions for individualizing motor activity instruction so that persons with severe handicaps can participate in appropriate recreation activities geared to their ability levels. These activities can be conducted in schools and large residential facilities, as well as in community-based settings.

GOALS AND OBJECTIVES

**LONG – TERM GOAL –** The long-term goal is a global statement about what you feel your participant can accomplish in a one-or two-year time period.

The participant will demonstrate motor and sensory-motor skills, appropriate behavior, and an understanding of the skills and rules of the Motor Activities Training Program that will enable him/her to successfully take part in training day activities and official Special Olympics sports.

**SHORT TERM OBJECTIVES –** Choose two to four short-term objectives that you feel your participant can achieve in an 8- to 16-week training program:

**1.** Given demonstration and practice, the participant will warm-up properly (with assistance as needed) before performing motor activities.

**2.** Given demonstration and practice, the participant will demonstrate an awareness of visual, auditory, and/or tactile stimulation.

**3**. Given demonstration and practice, the participant will successfully perform mobility activities.

**4.** Given demonstration and practice, the participant will successfully perform dexterity activities.

**5.** Given demonstration and practice, the participant will successfully perform striking activities.

**6.** Given demonstration and practice, the participant will successfully perform kicking activities.

**7.** Given demonstration and practice, the participant will successfully perform activities using a manual wheelchair.

**8.** Given demonstration and practice, the participant will successfully perform activities using an electric wheelchair (when appropriate).

**9.** Given demonstration and practice, the participant will successfully take part in aquatics activities.

**10.** Given demonstration and practice, the participant will successfully participate in age-appropriate modified group games and sports.

**11.** Given that the participant has successfully completed a six-to-eight-week training program, the participant will take part in a training day.

**12.** Based on the participant's motor skills, he/she will take part in official Special Olympics sports, training day activities, and/or community- based sport and recreation activities.

The MATP is being introduced to Special Olympics Wisconsin (SOWI) programs through a series of coaches certified training schools. SOWI strongly encourages each program interested in developing the MATP to have at least one of their coaches become certified as a MATP coach. Coaches' certification is not a requirement, but will greatly aid in delivering a quality MATP program to the Special Olympics athletes.

To assist programs with implementing the MATP program, SOWI will provide cost-free challenge award ribbons. Special Olympics athletes who complete an eight-week training session and participate in training day activities are eligible to receive a ribbon. In order to be sanctioned as an official SOWI MATP program and receive the challenge award ribbons, a program must submit a sanction form at least eight weeks prior to the scheduled training day. (NOTE: This is to insure an adequate supply of challenge award ribbons are on hand.)

Questions on MATP can be answered by contacting the SOWI Sports Department at (800) 222-1324 or visit www@specialolympicswisconsin.org.

# SPORTS COMPETITION EVENT GRANT FORM

## INTENT:

To support registered Agencies of Special Olympics Wisconsin in their efforts to organize, promote and implement multi-Agency team competitions in sports offered by Special Olympics Wisconsin.

## APPLICATIONS:

Grants for competitions may be used only to offset officials' fees, facility costs, equipment rental fees, and crucial event costs. (NOTE: Awards, travel, mementos, etc. are not applicable costs for grant expenditures.)

## REQUIREMENTS:

1. Grant applications are to be submitted by a representative of a registered (current) SOWI Agency.
2. The competition (i.e., tournament, meet, etc.) must involve a minimum of three different SOWI Agencies.
3. The competitive event in question must utilize properly certified/current sport officials and follow applicable SOI, SOWI and National Governing Body rules.
4. SOI and SOWI awards policies must be followed.
5. Each grant application must be accompanied by a rough draft of the organizational aspects of the event schedule in question; i.e., competition format, numbers of teams to be involved, any committee structure, site, date, etc.
6. Each grant must include a budget listing overall tournament expenses and how grant money will be allocated, plus overall expenses.
7. A grant application must be received at your SOWI **Area office** a minimum of thirty (30) days in advance of the date of the event.

## RESTRICTIONS:

1. A registered SOWI Agency may receive more than one grant per program year and multiple grant applications are encouraged.
2. A maximum award of $400.00 is available for each grant application.
3. Grants are not applicable toward SOWI-sponsored area, district, regional or state events.
4. Grants will be issued on a "first-come, first-served" basis; forms received will be date-stamped, awarded by merit and in order of receipt. (When grant money is no longer available, agencies will be notified.)

## REVIEW PROCESS/AWARDS:

All grants will be reviewed as soon as possible after receipt and any follow-up contacts will be made at that time. Final notification of grant approval and amounts to be received will be as expeditious as possible to facilitate the applicant's event planning processes.

# SPORTS COMPETITION EVENT GRANT FORM

EVENT TITLE: _____

DATE: _____ SPORT: _____

FACILITY TO BE USED: _____

APPLICANT'S NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

WORK PHONE: (_____) _____

HOME PHONE: (_____) _____

AGENCY NUMBER: _____ AGENCY NAME: _____

GRANT AMOUNT DESIRED: _____

(Maximum is $400.00)

**INTENT OF GRANT FUNDS** (Briefly describe how money will be used): _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

**SIGNATURE OF APPLICANT**: _____ DATE: _____

**Please attach the event budget and submit to the Area office 30 days in advance of the event.**

| **OFFICE USE ONLY** | | | |
|---|---|---|---|
| Approved: | Denied: | Amount Awarded: | Date: |

# FILING PROTESTS AT EVENTS

1. Protests to the games rules committee may only be made concerning games presentation, structure and conduct.
2. Protests to the sports rules committee may only be made concerning competition of athletes within a venue, where within that competition, rulings are determined in regard to the fairness and equity of the competition.
3. All protests must be initiated prior to the presentation of awards.
4. Protests must be presented to the head official of the event immediately in an oral fashion so that the event officials may be made aware of the appeal.
5. The head official may rule on appeals immediately, but if the response of the head official does not resolve the protest, a formal protest may follow.
6. All formal protests must be submitted within a half hour of the event in question.
7. All protests must be made on this official form.
8. All protests will be brought to the attention of the sports rules committee for final resolution. The decision of this committee shall be final and binding unless this committee concludes that the protest concerns games presentation, structure and/or conduct, at which time the committee will refer the protest to the games rules committee.

## PROTEST FORM

Date: _____ Time Submitted: _____

Sport: _____ Event: _____

Age Group: _____ Division (Heat): _____

Athlete or Team Name: _____

Identification Number: _____ Agency Number: _____

Reason For Protest: _____

_____

_____

_____

_____

**Signature of Sport Head Coach:** _____

**********

## DECISION BY SPORTS RULES COMMITTEE

Protest Approved: _____ Protest Denied: _____

**Signed:** _____

Date: _____ Time: _____

# DISQUALIFICATIONS

All Special Olympics Wisconsin (SOWI) athletes who do not conform to the rules and regulations of the sport in which they are competing are subject to disqualification. All disqualifications are made by the judge or official responsible for each event. All disqualified athletes will be officially signaled as such at the time of the infraction. The judge or official declaring the disqualification will fill out an official event disqualification report and submit it to the sports rules committee.

Below is a sample of the form the official will use for disqualifications. Please note that aquatics uses a separate form.

## OFFICIAL EVENT DISQUALIFICATION REPORT

1. Event: _____ 2. Division: _____ 3. Lane: _____
4. Athlete Number: _____
5. Athlete Name: _____
6. Reason For Disqualification: _____

_____

_____

_____

_____

_____

_____

_____

7. **Judge's Signature:** _____
8. Time: _____ Date: _____

# SPECIAL OLYMPICS WISCONSIN
# PROPOSED RULE CHANGE FORM

**Name of Sport:** _____ **Date of Submission**: _____

**Mail form to:** **Special Olympics Wisconsin Sports Department**
**2310 Crossroads Dr**
**Suite 1000**
**Madison, WI 53718**

**Submit by:** **May 1st Annually**

**Or, e-mail to:** bwhitehead@specialolympicswisconsin.org

**Recomended change to:** ☐ General Sports Rules/ Policies
☐ Sport Specific Rules/ Policies
Sport: _____

Official Special Olympics Sports Rules Version you are reading from for this change: _____

Rule Reference (i.e. General Information Section – Competition Guide, or Athletics — Section E-Rules of Competition, 1.b.)

_____

Page Number _____

Rule as it Reads: _____

_____

_____

**Recommendation: (Check the Box of the action proposed)**
☐ Delete rule ☐ Add new rule ☐ Change to read as follows:

_____

_____

_____

_____

**Reason for Proposed Rule Change:**

_____

_____

_____

Person Submitting Rule Change: _____

Address: _____

Agency: _____

Daytime Telephone Number: _____ E-mail Address: _____

.....

## For Rules Committee Use Only

☐ APPROVE AS PROPOSED

☐ NOT APPROVED

☐ REFER TO SPORTS RESOURCE TEAM FOR ADDITIONAL INFORMATION

☐ APPROVED WITH THE FOLLOWING REVISIONS:

_____

# INTERNATIONAL RULE CHANGE FORM

Name of Sport _____ Date of Submission: _____

Mail form to: **Sports Rules Advisory Committee (SRAC)**
**c/o Sports Department**
**Special Olympics Inc.**
**1133 19th Street, NW**
**Washington, DC 20036**
**USA**

Or, e-mail to: sportsrules@specialolympics.org

Official Special Olympics Sports Rules version you are reading from for this change: _____

Rule reference (i.e. Cycling — Section E-Rules of Competition, 1.b.)

Please see attached file. New events, etc are outlined in red. _____

Page number _____

Rule as it reads: _____

_____

Recommendation: (Check the box of the action proposed)

☐ Delete rule

☐ Add new rule

☐ Change to read as follows:

_____

_____

Reason for proposed rule change:

Addition of developmental events for athletes who do not have the ability to compete in novice, intermediate and advanced leves. In addition, additional rules for addition of a snowboard cross event.

Has this rule change been field tested/ utilized? If so, where and with what results?

_____

_____

Affiliated Special Olympics Program: _____

Rule change submitted on behalf of Special Olympics Program:

☐ YES

☐ NO

Person submitting rule change: _____

Address: _____

Daytime telephone number: _____

……

## For Rules Committee Use Only

☐ APPROVE AS PROPOSED

☐ NOT APPROVED

☐ REFER TO SPORTS RESOURCE TEAM FOR ADDITIONAL INFORMATION

# MEDICAL REFUND REQUEST

Directions:

- Complete this form and attach a doctor's explanation.
- Mail To:

SPECIAL OLYMPICS WISCONSIN
2310 CROSSROADS DRIVE, SUITE 1000
MADISON, WI 53718

The request and doctor's report must be received within 10 days of the conclusion of the event. Late or incomplete requests will be denied. If approved, the refund check will be mailed in the Agency's name to the Agency manager.

Athlete Name: _____

Agency Number: _____ Agency Name: _____

Event: _____

**A medical refund is requested for the athlete above. The doctor's explanation is attached.**

Contact Name: _____

Signed: _____

Date: _____

## SPECIAL OLYMPICS WISCONSIN – USE ONLY

Approved: _____ $ _____

Denied: _____ Coding Expense: _____

Signed: _____

**Chief Operating Officer (COO)**

Check Number: _____ Date: _____

# Special Olympics Wisconsin
# FUNDRAISING PROJECT APPLICATION

Name of project: _____

This project is on behalf of: _____

Local Agency

Individuals or Organizations involved in project: _____

Project date(s): _____

Give a brief description of the project: _____

_____

_____

Is a raffle being held in conjunction with this event? ☐ No ☐ Yes*
*If yes, see raffle requirements in Fund Raising section of the Agency Manager Handbook

Will the Special Olympics name or logo be used?

☐ No ☐ Yes (If yes, attach a sample of material(s))

Estimated dollars to be raised (gross income): $

Estimated expenses: $

Estimated dollars to local Agency: $ _____

Submitted by: _____

Name Title

_____

Mailing Address Telephone

_____

Email Address

**RETURN TO REGIONAL OFFICE 30-60 DAYS PRIOR TO EVENT**

Approved: _____

Regional Director of Development Date

# Special Event Summary

**Agency/Region:** _____ **Agency/Region Staff Time Involved:** _____

**Event:** _____ **Number of Volunteers: Prior to Event** _____

**Dates:** _____ **Day of Event** _____

**List of Corporate Sponsors**

| **Name** | **Cash Actuals** | **In-Kind Actuals** |
|---|---|---|
| **1.** | | |
| **2.** | | |
| **3.** | | |
| **4.** | | |

| **Expenditures** | | **Income** | | |
|---|---|---|---|---|
| | Cash Actuals | Source (pledges, auction, etc.) | In-Kind | Cash Actuals |
| Prizes | | 1. | | |
| Event Food | | 2. | | |
| Printing/Photography | | 3. | | |
| Facilities | | 4. | | |
| Appreciation/Hospitality | | 5. | | |
| Administrative | | 6. | | |
| (Insurance) | | 7. | | |
| (Permits) | | 8. | | |
| (Postage) | | 9. | | |
| Incentives/Souvenirs | | 10. | | |
| | | 11. | | |
| | | 12. | | |
| Sales Tax | | 13. | | |
| Miscellaneous | | 14. | | |
| **Total Expense** | **$** | **Total Income** | **$** | **$** |
| **Net** (Income - Expense) | **$** | | | |
| **Cost to Raise a Dollar :** (Total Expense ÷Total Income) | | | | |
| **Intangible assets of doing this event:** | | | | |
| | | | | |