Special Olympics BC
Volunteer Medical Form
Program Year 2015/2016

Date Started in Special Olympics (DD-MMM-YYYY): _____

PERSONAL INFORMATION Please Print Legibly

First Name: _____ Last Name: _____

Address: _____

City: _____ Postal Code _____

Phone: _____ Fax: _____ Cell: _____

E-Mail: _____

Sex (M or F): _____ Birth date (DD-MMM-YYYY): _____ Local 5B

EMERGENCY CONTACT

Name: _____ Phone #: _____

Relationship to Volunteer: _____

Other Information: _____

MEDICAL INFORMATION & HISTORY

MSP/Care Card Number: _____

Doctor's Name: _____ Phone #: _____

Medical Conditions: _____

Allergies: _____

Dietary Restrictions: _____

MEDICATION

_____

_____

_____

_____

_____

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I acknowledge that all the information given on this form is correct, to the best of my knowledge, and that I will update this information as it changes.

_____ _____

Applicant's signature Date (DD-MMM-YYYY)