

**SPECIAL OLYMPICS BC – \_\_\_\_\_ - MEDICAL RECORD**

PERSONAL (please PRINT)		
First Name	Last Name:	E-Mail Address
Address:		City: Postal Code:
Phone #:	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	Birth Date:
Care Card #:	Doctor's Name:	Doctor's Phone:

SPORT(S) REGISTERED FOR					
5-Pin Bowling <input type="checkbox"/>	Alpine Skiing <input type="checkbox"/>	Snowshoeing <input type="checkbox"/>	Aquatics <input type="checkbox"/>	Floor Hockey C <input type="checkbox"/>	Softball/T-Ball <input type="checkbox"/>
10-Pin Bowling <input type="checkbox"/>	X-Country Skiing <input type="checkbox"/>	Track & Field <input type="checkbox"/>	Rhythmic Gymnastics <input type="checkbox"/>	Floor Hockey S <input type="checkbox"/>	Soccer <input type="checkbox"/>
Basketball <input type="checkbox"/>	Golf <input type="checkbox"/>	Active Start <input type="checkbox"/>	FUNDamentals <input type="checkbox"/>	Bocce <input type="checkbox"/>	Weight Training <input type="checkbox"/>
Running Club <input type="checkbox"/>	Walking Club <input type="checkbox"/>	Figure Skating <input type="checkbox"/>	Curling <input type="checkbox"/>	Fitness <input type="checkbox"/>	Power Lifting <input type="checkbox"/>

EMERGENCY CONTACT(S)		
Name	Phone #:	Relationship:
Name:	Phone	Relationship:

MEDICAL (answer ALL questions)		
<b>Down Syndrome:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Date of Last Atlanto-Axial X-Ray: Result: Negative / Positive If positive, release form signed: Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Seizures:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Type: Frequency: Treatment:	<b>Heart Condition::</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: <b>Diabetes::</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Treatment:
<b>Cerebral Palsy:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Asthma:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Tetanus Shot:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Date:
<b>Allergies:</b> <b>Food:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> List: <b>Medication:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> List: <b>Other:</b>		Athlete has or uses the following: Glasses <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Dentures <input type="checkbox"/> Contact Lenses <input type="checkbox"/> Medical Alert <input type="checkbox"/> Other:

MEDICATION (must be updated prior to any trips) please PRINT			
Name of Medication (PRINT)	Dosage (i.e. 10mg 1 x day)	Time(s) of day	Self Administered
			Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>

OTHER IMPORTANT INFORMATION (please PRINT)

<p><b>Print Name of Person Completing this Form:</b> _____</p> <p>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.</p> <p>Relationship to Athlete: _____</p>	<p>_____</p> <p>(Signature) <span style="margin-left: 100px;">(Date)</span></p>
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