



BC Special Olympics Volunteer Medical Form Program Year 2009/2010



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

Medical Insurance Number: _____
 Doctor's Name: _____ Phone #: _____
 Medical Conditions: _____
 Allergies: _____
 Dietary Restrictions: _____

MEDICATION

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)