



Special Olympics BC Volunteer Medical Form Program Year 2010/2011



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)