

SPECIAL OLYMPICS BC - 2011-2012 - MEDICAL RECORD

PERSONAL (PLEASE PRINT AND FILL IN ALL FIELDS)

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:

PLEASE CHECK OFF ALL SPORT(S) YOU WISH TO 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 <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 D <input type="checkbox"/>	Soccer <input type="checkbox"/>
Basketball <input type="checkbox"/>	Golf <input type="checkbox"/>	Learn to Skate <input type="checkbox"/>	FUNDamental (7-12) <input type="checkbox"/>	Bocce <input type="checkbox"/>	Soccer Youth (13-18) <input type="checkbox"/>
Running Club <input type="checkbox"/>	Speed Skating <input type="checkbox"/>	Figure Skating <input type="checkbox"/>	Track Youth (13-18) <input type="checkbox"/>	Fitness <input type="checkbox"/>	Weight Training <input type="checkbox"/>
Snag (Intro to golf) <input type="checkbox"/>	Walking Club <input type="checkbox"/>	Curling <input type="checkbox"/>	Active Start <input type="checkbox"/>	T-Ball <input type="checkbox"/>	Power Lifting <input type="checkbox"/>

EMERGENCY CONTACT(S) – Must be available while athlete is at practice

Name:	Phone #:	Relationship:
Name:	Phone #:	Relationship:

MEDICAL (answer ALL questions)

Down Syndrome: 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"/>	Seizures: Yes <input type="checkbox"/> No <input type="checkbox"/> Type: Frequency: Treatment:	Heart Condition:: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: Diabetes:: Yes <input type="checkbox"/> No <input type="checkbox"/> Treatment:
Cerebral Palsy: Yes <input type="checkbox"/> No <input type="checkbox"/> Autism: Yes <input type="checkbox"/> No <input type="checkbox"/>	Asthma: Yes <input type="checkbox"/> No <input type="checkbox"/>	Tetanus Shot: Yes <input type="checkbox"/> No <input type="checkbox"/> Date:
Allergies: Food Allergies: Yes <input type="checkbox"/> No <input type="checkbox"/> List: Medication Allergies: Yes <input type="checkbox"/> No <input type="checkbox"/> List: Other Allergies:		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 - NO ABBREVIATION-

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: IE ANY PRE-EXISTING PHYSICAL OR BEHAVIOURAL LIMITATIONS THAT THE COACH MAY NEED TO KNOW

Print Name of Person Completing this Form: _____

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.

Relationship to Athlete: _____

(Signature)

(Date)