SAVE

# ATHLETE REGISTRATION FORM (2022 / 2023)

Special Olympics British Columbia

## SOBC Local: Vancouver

☐ Returning Athlete ☐ New Athlete

**Local is the community you wish to participate in

| ATHLETE INFORMATION | | |
|---|---|---|
| First Name: | Last Name: | |
| Date of Birth (mm/dd/yyyy): | Gender: | |
| Athlete Email for Portal Account: | | |
| (Optional)Parent/Guardian/Caregiver Email: | | |
| Street Address: | City: | |
| Postal Code: | Cell Phone: | Home Phone: |
| Athlete Living Situation: ☐ Parent / Guardian ☐ Caregiver ☐ Group Home ☐ Independent | | |

**SPORTS PROGRAMS** (indicate sports athlete would like to register for – sports offered will vary by Local)

| | | |
|---|---|---|
| ☐ 5-Pin Bowling | ☐ Figure Skating | ☐ Snowshoeing |
| ☐ 10-Pin Bowling | ☐ Floor Hockey | ☐ Speed Skating |
| ☐ Alpine Skiing | ☐ Intro to Golf | ☐ Swimming |
| ☐ Basketball | ☐ Golf | ☐ Track & Field |
| ☐ Bocce | ☐ Powerlifting | ☐ Active Start (ages 2-6) |
| ☐ Cross Country Skiing | ☐ Rhythmic Gymnastics | ☐ FUNdamentals (ages 7-11) |
| ☐ Curling ☐ Fit Families and Friends | ☐ Soccer ☐ Weight Training | ☐ Club Fit (Fitness) |
| ☐ Skate Skills | ☐ Softball ☐ Walking Club | ☐ Athlete Leadership Program |

| PARENT / GUARDIAN / CAREGIVER INFORMATION (required if athlete is under 19 or otherwise has a legal guardian) | | |
|---|---|---|
| Name: | Relationship to Athlete: | |
| ☐ Same Contact Info as Athlete (please list anything different below) | | |
| Street Address: | City: | |
| Postal Code: | Home Phone: | Cell Phone: |
| Email: | | |

| EMERGENCY CONTACT INFORMATION | |
|---|---|
| Primary Contact Name: | |
| Relationship to Athlete: ☐ Parent/Guardian ☐ Spouse ☐ Friend ☐ Relative | |
| Home Phone: | Cell Phone: |
| Secondary Contact Name: | |
| Relationship to Athlete: ☐ Parent/Guardian ☐ Spouse ☐ Friend ☐ Relative | |
| Home Phone: | Cell Phone: |

**ATHLETE NAME: _____ SOBC LOCAL: Vancouver**

| **MEDICAL INFORMATION (if more space is needed, please attached a separate sheet)** | |
|---|---|
| **Health Card #:** | |
| **Physician Name:** | **Physician Phone:** |
| **Medications & Dosages (please list)** **Self-Administered** ☐ **Yes** ☐ **No** | |
| **Seizures:** ☐ **Yes** ☐ **No** **If yes, please indicate seizure type, frequency, and treatment plan:** | |
| **Allergies:** ☐ **Yes** ☐ **No** **If yes, please provide Allergy Detail (including food, drugs, or other)** | |
| **Allergy Treatment (ie. does the athlete carry an epi-pen, medication, etc.)** | |

| **Down Syndrome** ☐ **Yes** ☐ **No** | **AAXray Date:** | **AAXRay Result:** ☐ **Positive** ☐ **Negative** |
|---|---|---|

**Medical Conditions:**

☐ Arthritis ☐ Asthma ☐ Depression ☐ Epilepsy ☐ High Blood Pressure
☐ Diabetes (if yes please indicate treatment below in medical notes)
☐ Other (if yes please provide details below in medical notes)

**Health Devices (please list if athlete has glasses, contacts, hearing aids, etc.):**

**Dietary Requirements (please indicate any specific dietary requirements i.e., gluten or lactose free):**

**Medical Notes (please include any additional information):**

*By filling in my name below I acknowledge that the information provided on this form is correct to the best of my knowledge and I will update this information should it change*

| **ATHLETE SIGNATURE (if 19 years or over)** | |
|---|---|
| **Athlete Signature:** | **Date:** |
| **PARENT/GUARDIAN SIGNATURE (required for athlete under 19 or who requires legal guardian to sign legal documents)** | |
| **Parent/Guardian Signature:** | **Date:** |
| **Printed Name:** | **Relationship to Athlete:** |

****If filling in and submitting the form online, you may type your name in the signature line****