VOLUNTEER REGISTRATION FORM (2021 / 2022)

Special Olympics British Columbia

SOBC Local**: VICTORIA

☐ Returning Volunteer ☐ New Volunteer

***Local is the community you wish to volunteer with*

VOLUNTEER INFORMATION		
First Name:	**Last Name:**	
Date of Birth (mm/dd/yyyy):	**Gender:**	
Email:		
Street Address:	**City:**	
Postal Code:	**Home Phone:**	**Cell Phone:**
NCCP# (if known):		

VOLUNTEER POSITIONS (please check the roles you are interested in)

Sport Programs

☐ 5-Pin Bowling ☐ 10-Pin Bowling	☐ Figure Skating ☐ Learn to Skate	☐ Swimming (Tues)
☐ Basketball	☐ Floor Hockey ☐ Speed Skating	☐ Swimming (Thurs)
☐ Bocce	☐ Golf	☐ Swimming (Thurs/Shallow)
☐ Curling	☐ Powerlifting	☐ Active Start (ages 2-6)
☐ Track & Field	☐ Rhythmic Gymnastics	☐ FUNdamentals (Monday/Fall)
☐ Athletic Club (12yrs+)	☐ Soccer	☐ FUNdamentals (Tuesday/Fall)
☐ Club Fit (Fall) ☐ Club Fit (Spring)	☐ Softball ☐ T-Ball	☐ FUNdamentals (Spring)

I'm interested in role of ☐ Head Coach ☐ Assistant Coach ☐ Program Volunteer

Administration Roles

Executive		**Other Roles**
☐ Local Coordinator	☐ Fundraising Coordinator	☐ General Volunteer
☐ Treasurer	☐ Public Relations Coordinator	☐ Event Volunteer
☐ Program Coordinator	☐ Registration Coordinator	☐ Other
☐ Volunteer Coordinator	☐ Secretary	

Additional comments on the volunteer roles you are interested in (optional)

REFERENCES – Please provide two references (only required for NEW volunteers)

Name:	**Phone:**	**Email:**
Relationship to volunteer applicant:		
Name:	**Phone:**	**Email:**
Relationship to volunteer applicant:		

Volunteer Name: _____ SOBC LOCAL: VICTORIA

PARENT / GUARDIAN INFORMATION (only required if volunteer is under 19)		
Name:	**Relationship to Volunteer:**	
☐ **Same Contact Info as Volunteer (please list anything different below)**		
Street Address:	**City:**	
Postal Code:	**Home Phone:**	**Cell Phone:**
Email:		
EMERGENCY CONTACT INFORMATION		
Contact Name:		
Relationship to Volunteer: ☐ **Parent/Guardian** ☐ **Spouse** ☐ **Friend** ☐ **Relative**		
Home Phone:	**Cell Phone:**	
MEDICAL INFORMATION		
Health Card #:		
Physician Name:	**Physician Phone:**	
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 volunteer carry an epi-pen, medication, etc.):		
Medical Notes (please include additional information as applicable)		

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	
VOLUNTEER SIGNATURE **(if 19 years or over)**	
Volunteer Signature:	**Date:**
PARENT/GUARDIAN SIGNATURE **(required for volunteer who is under 19)**	
Parent/Guardian Signature:	**Date:**
Printed Name:	

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