



Athlete Registration Form 2018-2019

Does the applicant have an Intellectual Disability? YES NO

ATHLETE TITLE	Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/>	LAST NAME		<i>Numerical Identifier – Office Use Only</i>
FIRST NAME		MIDDLE NAME OR INITIAL		
HOME ADDRESS & CONTACT INFORMATION	Street Name & No.		Apt. No. or R.R. No.	
	City		Province	Postal Code
	Home Phone No.		Cell/Mobile No.	E-mail Address
EMERGENCY CONTACT	Name		Relationship	
	Home Phone No.		Work Phone No.	
	Cell No.		E-mail address	
GENDER	Male <input type="checkbox"/> Female <input type="checkbox"/>		DATE OF BIRTH	Month Day Year
CONTACT METHOD	Phone <input type="checkbox"/> E-mail <input type="checkbox"/> Fax <input type="checkbox"/>		T-SHIRT SIZE	S <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> XL <input type="checkbox"/>
	Mail to Home <input type="checkbox"/> Mail to School/Business <input type="checkbox"/>			Other _____
PARENT/ GUARDIAN INFORMATION	First Name		Last Name	
	Street Name & No.		Province	Postal Code
	City			
	Home Phone No.		Work Phone No.	E-mail address
LIVING SITUATION	<input type="checkbox"/> Parental <input type="checkbox"/> Non-parental Family <input type="checkbox"/> Foster Parents/Caregiver/Guardian <input type="checkbox"/> Independent <input type="checkbox"/> Group Home <input type="checkbox"/> Supported Independent Living <input type="checkbox"/> Prefer not to say			
	Name of Group Home:		Group Home Phone #:	
	Name of Support Worker:		Support Worker Phone #:	
MEDICAL INFORMATION	Provincial Health Card Number		Expiry Date	Issuing Province
	Doctors' Name			Doctor's Phone No.
	Allergies		Dietary Restrictions	
	Medication (You must let us know when there are changes to medications)			
	Please attach a separate sheet of current medications. Include name of medication(s), dosages, time(s) administered and whether or not they are self administered. If hand written, it MUST be printed clearly.			
	Does Applicant have any of the following medical conditions:			
	Diabetes <input type="checkbox"/>	Cerebral Palsy <input type="checkbox"/>		
	Heart Condition <input type="checkbox"/>	Asthma <input type="checkbox"/>		
Autism <input type="checkbox"/>	Other (Please specify): _____			
Does Applicant have seizures <input type="checkbox"/> No <input type="checkbox"/> Yes IF YES, PLEASE INDICATE HOW THESE ARE CONTROLLED				
Down Syndrome Information				
<input type="checkbox"/> No <input type="checkbox"/> Yes IF YES, PLEASE COMPLETE INFORMATION BELOW				

DATE OF LAST ATLANTO-AXIAL DISLOCATION X-RAY

Month Day Year

WAS THE X-RAY NEGATIVE OR POSITIVE?

Negative Positive

PROGRAMS OFFERED

Community Sport Stream

- Active Start (2-6 years)
- FUNdamentals (7-12 years)
- Adult Sport Programs (13+ yrs.)

PLEASE CHECK ALL SPORTS THAT YOU INTEND TO PARTICIPATE IN:

- | | | | |
|------------------------------------|---|---|--|
| <input type="checkbox"/> Athletics | <input type="checkbox"/> Cross Country Skiing | <input type="checkbox"/> Snowshoeing | <input type="checkbox"/> Floor Hockey |
| <input type="checkbox"/> Bocce | <input type="checkbox"/> Rhythmic Gymnastics | <input type="checkbox"/> Powerlifting | <input type="checkbox"/> Curling |
| <input type="checkbox"/> Soccer | <input type="checkbox"/> Swimming | <input type="checkbox"/> Speed Skating | <input type="checkbox"/> Alpine Skiing |
| <input type="checkbox"/> Softball | <input type="checkbox"/> Basketball | <input type="checkbox"/> 5-Pin Bowling | |
| <input type="checkbox"/> Golf | <input type="checkbox"/> Figure Skating | <input type="checkbox"/> 10-Pin Bowling | |

Competitive Sport Stream

* FOR THE COMPETITIVE SPORT STREAM, PLEASE CHECK ONLY **ONE** OF THE FOLLOWING SPORTS PER SEASON:

WINTER SPORTS

- Floor Hockey
- Curling
- Figure Skating
- Speed Skating
- Snowshoeing
- Nordic Skiing
- Alpine Skiing
- 5-Pin Bowling

SUMMER SPORTS

- Athletics
- Swimming
- Softball
- Soccer
- Basketball
- Rhythmic Gymnastics
- 10-Pin Bowling
- Powerlifting
- Bocce
- Golf

Does the applicant have a criminal record of any kind, or have they ever been charged with a criminal offence? YES NO

If yes, please indicate the nature of the offence: _____

I HAVE READ THE FOLLOWING DOCUMENTS AND AGREE TO THEIR GUIDELINES:

- 1) CODE OF CONDUCT (FOUND ONLINE AT WWW.SOPEI.COM)
- 2) CRIMINAL RECORD INFORMATION

WAIVER AND RELEASE

I, THE UNDERSIGNED ATHLETE, PARENT AND/OR LEGAL GUARDIAN OF THE ABOVE NAMED ATHLETE, HEREBY REQUEST PERMISSION FOR THE ATHLETE TO PARTICIPATE IN THE SPECIAL OLYMPICS CANADA INC. PROGRAM. I REPRESENT AND WARRANT YOU THAT THE ATHLETE IS PHYSICALLY AND MENTALLY ABLE TO PARTICIPATE IN SPECIAL OLYMPICS CANADA. ON BEHALF OF THE ATHLETE AND MYSELF, I ACKNOWLEDGE THAT THE ATHLETE WILL BE USING FACILITIES AT THEIR OWN RISK AND I, ON MY OWN BEHALF, HEREBY RELEASE, DISCHARGE AND INDEMNIFY SPECIAL OLYMPICS CANADA INC. FROM ALL LIABILITY FOR INJURY TO PERSON OR DAMAGE TO PROPERTY OF MYSELF OR ENTRANT. IN PERMITTING THE ATHLETE TO PARTICIPATE I AM SPECIFICALLY GRANTING PERMISSION TO YOU TO USE THE LIKENESS, VOICE AND WORDS OF THE ATHLETE ON TELEVISION, RADIO, FILMS, NEWSPAPER, MAGAZINE AND OTHER MEDIA, AND IN ANY FORM NOT HEREBY DESCRIBED FOR THE PURPOSE OF ADVERTISING OR COMMUNICATING THE PURPOSES AND ACTIVITIES OF SPECIAL OLYMPICS CANADA ACTIVITIES IN WHICH THE ATHLETE IS TO COMPETE, SO AS TO BE CONSULTED IN CASE OF NECESSITY, YOU ARE AUTHORIZED ON MY BEHALF AND AT MY ACCOUNT TO TAKE SUCH MEASURES AND ARRANGE FOR SUCH MEDICAL AND HOSPITAL TREATMENT AS YOU MAY DEEM ADVISABLE FOR THE HEALTH AND WELL-BEING OF THE ATHLETE.

ANY AND ALL REFERENCES TO SPECIAL OLYMPICS CANADA INC. INCLUDE AND APPLY EQUALLY TO THE PROVINCIAL AND TERRITORIAL CHAPTERS OF SPECIAL OLYMPICS INC.

PRIVACY POLICY

SPECIAL OLYMPICS PRINCE EDWARD ISLAND (SOPEI) WILL PROTECT YOUR PERSONAL INFORMATION AND ADHERE TO ALL LEGISLATIVE REQUIREMENTS WITH RESPECT TO YOUR PRIVACY. WE USE YOUR PERSONAL INFORMATION TO PROVIDE SERVICES AND KEEP YOU INFORMED AND UP TO DATE ON THE ACTIVITIES OF SOPEI, INCLUDING PROGRAMS, SERVICES, SPECIAL EVENTS, FUNDING REQUIREMENTS, MEDIA, AND OPPORTUNITIES TO VOLUNTEER OR TO GIVE.

I DO NOT PERMIT SOPEI TO PROVIDE ANY THIRD PARTIES MY PERSONAL INFORMATION (PLEASE CHECK)

Athlete or Guardian _____ If Guardian, what is relationship _____
Print Name

Signature _____ Date _____

Submit to:

Special Olympics Prince Edward Island
40 Enman Crescent, Room 240 Charlottetown, PEI C1E 1E6
Phone: 902-368-8919 Toll Free:1-800-287-1196 Fax: 902-892-4553