ATHLETE REGISTRATION FORM (2023 / 2024)

Special Olympics British Columbia

SOBC Local: _____ ☐ 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	☐ Golf	☐ Swimming
☐ Basketball	☐ Powerlifting	☐ Track & Field
☐ Bocce	☐ Rhythmic Gymnastics	☐ Active Start (ages 2-6)
☐ Cross Country Skiing	☐ Soccer	☐ FUNdamentals (ages 7-11)
☐ Curling	☐ Softball	☐ Club Fit (Fitness)
		☐ 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:** _____

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****