Special Olympics British Columbia

SPECIAL OLYMPICS BC - VOLUNTEER MEDICAL FORM

PROGRAM YEAR: ____________________

FIRST NAME: ________________________ LAST NAME: ________________________

ADDRESS: ____

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CITY: _______________________________ POSTAL CODE: _____________________

PHONE: _____________________________ EMAIL: ____________________________

SEX: (M/F/U) _____ BIRTH DATE: ___________ LOCAL: __________

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SPORTS: (Please only circle programs that you currently coach or volunteer with)

Athletic Club	Floor Hockey	Figure Skating	Curling
Alpine Skiing	Swimming	Rhythmic Gym	Snowshoeing
Soccer	Softball	Powerlifting	Track & Field
Speed Skating	10-Pin Bowling	5-Pin Bowling	Bocce
Cross-Country Skiing	Golf	Basketball	Active Start
FUNdamentals	Sport Start	Club Fit	

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EMERGENCY CONTACT:

Contact 1: _____________________________________ Telephone: ________________

Relationship: (circle one) Parent Guardian Spouse Sibling Friend

Contact 2: _____________________________________ Telephone: ________________

Relationship: (circle one) Parent Guardian Spouse Sibling Friend

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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.

_____________________________ ____________

Signature of Person Completing Form Date

MEDICAL INFORMATION

Medical Insurance Number: ____

Doctor's Name: ___________________________________ Phone #: ________________

Seizures (Circle one:) No Yes (If yes, please fill out the next line.)

Type: ______________________ Frequency: ___________________________________

Treatment: ____

Medical History

Diabetic: (Circle one) No Yes Treatment: Diet Pill Injection Schedule_____

Tetanus Shot No Yes Within 5 years Within 10 years

Asthma No Yes

Cerebral Palsy No Yes

Heart Condition No Yes Other: _____________________________________

Allergies: (Please List) Food: ____

Drugs: ____

Other: ____

Does the athlete have or use any of the following:

Glasses Hearing aid Dentures Contact Lenses Other

MEDICATION (must be updated prior to any trips)

Self-Administered Yes No

Name & dosage: _______________________________________ Time/s: _____________

Name & dosage: _______________________________________ Time/s: _____________

Name & dosage: _______________________________________ Time/s: _____________

Name & dosage: _______________________________________ Time/s: _____________

Additional Comments:

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