

BC SPECIAL OLYMPICS – NORTH SHORE - MEDICAL RECORD

PERSONAL (please PRINT)		
First Name:	Last Name:	E-Mail Address:
Address:		City: Postal Code:
Phone #:	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	Birthdate:
Care Card #:	Doctor's Name:	Doctor's Phone:

SPORT(S) REGISTERED FOR					
Active Start (2-6) <input type="checkbox"/>	5-Pin Bowling <input type="checkbox"/>	Fit Club <input type="checkbox"/>	FUNdamentals (7-10) <input type="checkbox"/>	Soccer <input type="checkbox"/>	Sport Start (11-18) <input type="checkbox"/>
Alpine Skiing <input type="checkbox"/>	10-Pin Bowling <input type="checkbox"/>	Floor Hockey B <input type="checkbox"/>	Golf <input type="checkbox"/>	Softball B <input type="checkbox"/>	(was Youth Sports)
Basketball <input type="checkbox"/>	Cross Country Ski. <input type="checkbox"/>	Floor Hockey C <input type="checkbox"/>	Rhythmic Gym. <input type="checkbox"/>	Softball C <input type="checkbox"/>	Swimming <input type="checkbox"/>
				Snowshoeing <input type="checkbox"/>	Track & Field <input type="checkbox"/>

EMERGENCY CONTACT(S)		
Name:	Phone #:	Relationship:
Name:	Phone #:	Relationship:

MEDICAL (answer ALL questions)		
Down Syndrome: Yes <input type="checkbox"/> No <input type="checkbox"/> Date of Last Atlanto-Axial X-Ray: Result: Negative / Positive If positive, release form signed: Yes <input type="checkbox"/> No <input type="checkbox"/>	Seizures: Yes <input type="checkbox"/> No <input type="checkbox"/> Type: Frequency: Treatment:	Heart Condition:: Yes <input type="checkbox"/> No <input type="checkbox"/> Explain: Diabetes:: Yes <input type="checkbox"/> No <input type="checkbox"/> Treatment:
Cerebral Palsy: Yes <input type="checkbox"/> No <input type="checkbox"/>	Asthma: Yes <input type="checkbox"/> No <input type="checkbox"/>	Tetanus Shot: Yes <input type="checkbox"/> No <input type="checkbox"/> Date:
Allergies:	Food: Yes <input type="checkbox"/> No <input type="checkbox"/> List: Medication: Yes <input type="checkbox"/> No <input type="checkbox"/> List: Other:	Athlete has or uses the following: Glasses <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Dentures <input type="checkbox"/> Contact Lenses <input type="checkbox"/> Medical Alert <input type="checkbox"/> Other:

MEDICATION (must be updated prior to any trips) please PRINT			
Name of Medication (PRINT)	Dosage (i.e. 10mg 1 x day)	Time(s) of day given	Self Administered
			Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>

OTHER IMPORTANT INFORMATION INCLUDING MEDICAL OR BEHAVIOURAL INFORMATION THAT MIGHT BE HELPFUL TO THE COACHES (please PRINT)

Print Name of Person Completing this Form:	<input style="width: 95%;" type="text"/>
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.	
Relationship to Athlete:	<input style="width: 95%;" type="text"/>