



ATHLETE INFORMATION & MEDICAL HISTORY FORM

Date Completed (YYYY/MM/DD) _____ / _____ / _____ Last reviewed: 1 yr 2 yrs 3 yrs

1. Personal Information

Special Olympics Ontario (SOO) Registration number, if known: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Address _____ Apt/Unit# _____

City: _____ Province ONTARIO Postal Code _____

Athlete Home Phone Number: _____ **Athlete** Cell Number: _____

Athlete email: _____

Date of Birth _____ Gender : _____

2. Living Arrangements

Independent Family: Group Home: Other: _____

3. Parent, Caregiver, Emergency Contact(s)

	First Contact (required)	Second Contact
Contact Name:		
Relationship to Athlete:		
Phone Numbers: <i>(if different from the athlete)</i>		
Email:		

Additional contact information, if needed: _____

What is the best way to notify you of a change in schedule? If email is NOT the best way to contact you in the event of a cancellation. Please indicate the best phone number to call.

4. Medical Contact

Family Doctor: _____ Phone Number: _____
(please print name)

OHIP Number *(Optional, not required for completion of this form)* _____

5. Medical History

Please check Yes (Y) or No (N) for all areas:

Yes	No	Yes	No
	Food Allergies		Emotional/Psychological/Behaviour Problems
	Sting/Bite Allergies		Hearing Loss/Hearing Aid
	Medicine Allergies		Major Surgery or serious illness
	Do you carry an epi-pen?		Heat Stroke/Exhaustion
	Asthma		High Blood Pressure
	Do you carry an inhaler?		Medications (if yes, please indicate below)
	Blindness or Visual Problems		Non-Verbal
	Bone or Joint Problems		Seizures/Epilepsy/Fainting Spells
	Chest Pain		Date of last episode: _____
	Concussion or Serious Head Injury		How often? _____
	Diabetes		Requires Assistance
	Down Syndrome		Uses Wheelchair
	Atlanto-Axial Instability		Other: _____
	Easy Bleeding		

If you answered yes to any questions above, please elaborate in the boxes below. Please attach any additional information necessary:

Please explain any medical issues and how to address them (eg. List any allergies, response to seizures, ect., medications required for specific circumstances)

Please indicate any information that will benefit the athlete/coach training relationship (eg. Behaviour management, communications, limitations, ect.)

6. Medications

(Please attach any additional information necessary)

Does the athlete self-medicate

Yes

No

Medication Name	Dosage	Times Per Day
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Medication Name	Dosage	Times Per Day
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Medication Name	Dosage	Times Per Day
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Medication Name	Dosage	Times Per Day
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Important: I understand that the information contained in this form may be deemed confidential. I affirm that I have read the above and that the information I have given is true and complete. This form must be completed and signed in order to participant in any practice or sporting event

Signature: _____ Date: _____

Name in block capitals: _____

Relationship to Athlete (if not self): _____

Important: Information must be confirmed by the coaching staff or manager before the first practice of the year.

Date Information Confirmed	Date Information Revised	Athlete/Guardian Initials	Coach/Manager Initials
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