Athlete Registration Renewal Form

Required annually for all athletes participating in Special Olympics.

Special Olympics

Local Special Olympics Program: _____

Athlete Information - *To be completed by the athlete or parent/guardian/caregiver.*

First name: _____ Last name: _____ Middle name: _____

Date of birth (dd/mm/yyyy): _____/_____/_____ Gender: ◯ Female ◯ Male

Home address: _____ Country: _____

Phone number: _____ ◯ Mobile ◯ Landline

Have there been any changes to your health history in the past year? ◯ **Yes** ◯ **No**

If yes, please complete the health history section. If no, please complete the signature section.

Office Use Only:

Athlete ID: _____

Health History			
Health and/or mobility aids the athlete possesses and may use during Special Olympics participation.	☐ CPAP	☐ Eyeglasses/Contacts/Protective Eyewear	☐ Implantable Device for Seizure
	☐ Prosthetics	☐ Hearing Aid/Communication Device	☐ Wheelchair/Walker/Leg Braces
	☐ Dentures	☐ Pacemaker/Implanted Defibrillator	☐ VP Shunt
	☐ None	☐ Other: _____	
List any allergies and/or dietary requirements:			

General Health Questions:					
Do you have a heart condition?	◯ Yes	◯ No	Do you have asthma?	◯ Yes	◯ No
Have you ever had a head injury or concussion?	◯ Yes	◯ No	Do you have diabetes?	◯ Yes	◯ No
If yes, number of head injury/concussion(s): _____			Do you have a vision impairment?	◯ Yes	◯ No
Date of most recent head injury/concussion: _____			Do you have a hearing impairment?	◯ Yes	◯ No
Do you have a bleeding disorder?	◯ Yes	◯ No	Do you have sickle cell disease?	◯ Yes	◯ No
Do you have epilepsy or any type of seizure disorder?				◯ Yes	◯ No
Do you have behavioral, mental health, and/or sensory conditions that could impact your/other's participation?				◯ Yes	◯ No

If yes to any of the above general health questions, please provide additional details:

Medication and Treatment

Have there been any changes to your prescriptions, over-the-counter medications, or treatments? ◯ Yes ◯ No

If yes, please list below:

Medication, Vitamin, or Supplement Name	Dosage	Times per day

Medication, Vitamin, or Supplement Name	Dosage	Times per day

Do you have severe allergies that requires the use of an EpiPen? ◯ Yes ◯ No

If yes, please specify if it is to any of the following:

☐ Insect stings ☐ Medication/drugs ☐ Food ☐ Latex ☐ Other (please specify): _____

I certify the information provided on this form is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Is this form being completed by someone other than the athlete? ◯ Yes ◯ No

If yes, please select the relationship to athlete:

◯ Parent/Guardian ◯ Caregiver/Other Family Member ◯ Healthcare Provider ◯ Other: _____