

# Athlete Registration Renewal Form

**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

<b>Office Use Only:</b> Athlete ID: _____
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**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.*

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:					
<b>Medication, Vitamin, or Supplement Name</b>	<b>Dosage</b>	<b>Times per day</b>	<b>Medication, Vitamin, or Supplement Name</b>	<b>Dosage</b>	<b>Times per day</b>

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: _____		