Special Olympics Ontario

ATHLETE INFORMATION & MEDICAL HISTORY FORM

Date completed (MM/DD/YY): ____/____/____ **Last reviewed:** **1 yr** ☐ **2 yrs** ☐ **3 yrs** ☐

1. Personal Information **SOO Registration Number (if known):** _____

First Name _____ Middle Initial _____ Last Name _____

Address _____ Apt / Unit # _____

City _____ Province **ONTARIO** Postal Code _____

Home Phone Number (____) _____ Cell Phone Number (____) _____

e-mail (athlete) _____

_____/_____/_____ Gender: Male ☐ Female ☐
Date of Birth (MM/DD/YY) *optional

_____
OHIP Number *This information is provided voluntarily and not required for the completion of this form

2. Living Arrangements

Independent ☐ Family ☐ Group Home ☐ Other ☐ _____

3. Emergency Contact(s)

1. Name _____ Relationship to Athlete _____

Home Phone Number (____) _____ Cell Phone Number (____) _____

2. Name _____ Relationship to Athlete _____

Home Phone Number (____) _____ Cell Phone Number (____) _____

4. Medical Contact(s)

Family Doctor (please print name) _____

Phone Number (____) _____

5. Medical History

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

If yes, please specify in the boxes below

Y	N		Y	N	
☐	☐	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 If yes, date of last episode ____/____/____ (MM/DD/YY)
☐	☐	Chest Pain	☐	☐	If yes, commonly reoccurring
☐	☐	Concussion or Serious Head Injury	☐	☐	Requires Assistance
☐	☐	Diabetes	☐	☐	Uses Wheelchair
☐	☐	Down Syndrome	☐		Other _____
☐	☐	Atlanto-Axial Instability			
☐	☐	Easy Bleeding			

If you answered yes to any questions above, please elaborate in the boxes below:

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 athlete self-medicate? Yes ☐ No ☐

Medication Name	Dosage	Times per Day
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

Name (printed) _____ Signature _____

Relationship to Athlete _____ Date _____

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

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