Home address:

Phone number:  Mobile  Landline

Country:

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

Athlete Registration Renewal Form

Required annually for all athletes participating in Special Olympics.

**Local Special Olympics Program:**

First name:

Last name:

Middle name:

Date of birth (dd/mm/yyyy): */* */*

Gender:

Female

Male

Other

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

**Office Use Only:**

Athlete ID:

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 ShuntNone 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): Date of most recent head injury/concussion:  | Do you have a vision impairment? |  Yes  No |
| 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: |
|  |
| 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:  |

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|  |  |  |
| --- | --- | --- |
| **Medication, Vitamin, or Supplement Name** | **Dosage** | **Times per day** |
|  |  |  |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| **Medication, Vitamin, or Supplement Name** | **Dosage** | **Times per day** |
|  |  |  |
|  |  |  |