

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

Prefer not to answer

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

Home address:

Phone number:  Mobile  Landline

Country:

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

**Office Use Only:**

Athlete ID:

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

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| --- | --- | --- | --- | --- |
| **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):  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** |
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| --- | --- | --- |
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