Special Olympics British Columbia

SPECIAL OLYMPICS BC MEDICAL FORM

PROGRAM YEAR: 2019/ 2020

FIRST NAME: _____

LAST NAME: _____

ADDRESS: _____

CITY: _____ POSTAL CODE: _____

PHONE: _____ CELL: _____

EMAIL: _____

GENDER: _____ BIRTH DATE: _____ LOCAL: _____

BEST CONTACT:
Name: _____

Email: _____ Telephone: _____
Relationship to athlete: (check one) ☐ Parent ☐ Guardian ☐ Spouse ☐ Sibling ☐ Caregiver
Athlete lives independently: ☐ Yes ☐ No
****

SPORTS/PROGRAMS: (Check all that apply, but please only check programs athlete currently attends)

☐ 5-pin SAT.	☐ 10-pin bowling	☐ Alpine skiing	☐ Basketball	☐ Bocce	☐ ~~Cross country skiing~~
☐ 5-pin TUESD.	☐ Figure skating	☐ Floor hockey	☐ Golf	☐ ~~Powerlifting~~	☐ Rhythmic gymnastics
☐ Curling	☐ Softball	☐ Swimming	☐ Snowshoeing	☐ Speed skating	☐ Track and field
☐ Soccer	☐ FUNdamentals	☐ ~~Sport Start~~	☐ Club Fit	☐ Athletic Club	☐ Learn to Swim
☐ Active Start				☐ Learn to Skate	☐ Walking Club

****

EMERGENCY CONTACT:
Contact 1: _____
Telephone: _____ Cell: _____
Relationship to athlete: (check one) ☐ Parent ☐ Guardian ☐ Spouse ☐ Sibling ☐ Caregiver
Contact 2: _____
Telephone: _____ Cell: _____
Relationship to athlete: (check one) ☐ Parent ☐ Guardian ☐ Spouse ☐ Sibling ☐ Caregiver

Please provide any information (medical or otherwise) that you think would be pertinent or would enhance the athlete's participation in programs, competitions, or events:

Special Olympics British Columbia

NAME: _____ LOCAL: _____

MEDICAL INFORMATION

Medical Insurance Number: _____

Doctor's name: _____ Phone #: _____

MEDICAL HISTORY: (Please check all that apply)

Down syndrome: ☐ Yes ☐ No (If yes, please fill out the next line.)
Atlantoaxial X-ray date: _____ Positive: _____ Negative:_____

☐ Seizures (If yes, please fill out the next line.)
Type: _____ Frequency: _____ Date of last seizure: _____
Treatment Plan if applicable (attach additional sheet if required):
_____

☐ Diabetic – Treatment: Diet ☐ Pill ☐ Insulin ☐ Able to inject own insulin Yes ☐ No ☐
☐ Asthma ☐ High blood pressure ☐ Cerebral palsy ☐ Bed wetting ☐ Anxiety
☐ Arthritis ☐ Sleep apnea ☐ Tube feed ☐ Depression
☐ Heart condition – Please explain: _____

Does the athlete have or use any of the following – please check all that apply:
Glasses ☐ Contact lenses ☐ Hearing aid ☐ Dentures ☐ Wheelchair ☐ Cpap ☐ Other _____

ALLERGIES: (Please list)

Food: _____Reaction:_____
Drugs: _____ Reaction: _____
Other: _____
Have you ever experienced an anaphylactic reaction? ☐Yes ☐No Do you carry an EpiPen? ☐Yes ☐No
Tetanus up to date: Yes ☐ No ☐ Date last given:_____

MEDICATION: (Must be updated prior to any trips)

Self-administered: Yes ☐ No ☐
Name & dosage: _____ Time/s: _____
Name & dosage: _____ Time/s: _____
Name & dosage: _____ Time/s: _____
Name & dosage: _____ Time/s: _____
If more space is needed, please complete on a separate sheet

OTC: (Over the Counter medication)

*Are medications self-administered? ☐ Yes ☐ No Able to swallow pills? ☐ Yes ☐ No
Athlete may take the following medication: (**PLEASE CHECK ALL THAT APPLY**)

☐ Tylenol Regular (Acetaminophen)	☐ Aspirin	☐ Advil
☐ Tylenol Extra Strength	☐ Decongestants	☐ Antihistamines
☐ Gravol (incl. Ginger Gravol)	☐ Ibuprofen	☐ Immodium
☐ Pepto-Bismol	☐ Cough and cold medicine	☐ Antacids
☐ Benadryl	☐ Eye/ear drops	☐ Antibiotic ointment

I hereby give permission for _____ to be given the above checked
(Athlete name)
medication as needed. I acknowledge that all of the information given on this form is correct to the best of my knowledge and I will update this information as required.

Signature: _____ Date:_____
(Athlete signature)
Signature: _____ Date: _____
(Signature of parent or legal guardian if under the age of 18 years)