Athlete Registration Renewal Form

Required for athletes that have a change in contact information or health history prior to the 3-year expiration of the registration 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 ◯ Other

Home address: ____ Country: ____________________

Phone number: ____________________ ◯ Mobile ◯ Landline

Office Use Only:

Athlete ID: ______________

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 ☐ Prosthetics ☐ Dentures ☐ None	☐ Eyeglasses/Contacts/Protective Eyewear ☐ Hearing Aid/Communication Device ☐ Pacemaker/Implanted Defibrillator ☐ Other: ____________________	☐ Implantable Device for Seizure ☐ Wheelchair/Walker/Leg Braces ☐ VP Shunt
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:

Medication, Vitamin, or Supplement Name	Dosage	Times per day

Medication, Vitamin, or Supplement Name	Dosage	Times per day

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: ____________