



Special Olympics Zone/Community: _____ *

General Information

Member Since: _____

Name: _____ * Gender: Male Female *
Last First

Address: _____ *

City/Town: _____ * Province: _____ * Postal Code: _____ *

Home Phone: _____ * Work Phone: _____

Fax Number: _____ E-Mail: _____

Birth Date (DD-MMM-YYYY): _____ * Health Card Number: _____

Aboriginal Heritage: (Information used for Indigenous Games) Yes No

* These fields are mandatory

Sport Program Information

Please indicate the sport(s) the athlete will be participating in:

- | | | | |
|--------------------------------------|--------------------------------------|---|--|
| <input type="radio"/> 10-Pin Bowling | <input type="radio"/> Basketball | <input type="radio"/> Gymnastics | <input type="radio"/> Snowshoeing |
| <input type="radio"/> 5-Pin Bowling | <input type="radio"/> Curling | <input type="radio"/> Horseshoes | <input type="radio"/> Soccer |
| <input type="radio"/> Alpine Skiing | <input type="radio"/> Equestrian | <input type="radio"/> Nordic Skiing | <input type="radio"/> Softball |
| <input type="radio"/> Aquatics | <input type="radio"/> Figure Skating | <input type="radio"/> Other | <input type="radio"/> Speed Skating |
| <input type="radio"/> Athletics | <input type="radio"/> Floor Hockey | <input type="radio"/> Power-lifting | <input type="radio"/> Synchro-Swimming |
| <input type="radio"/> Bocce | <input type="radio"/> Golf | <input type="radio"/> Rhythmic Gymnastics | <input type="radio"/> Walking Program |

Athlete Medical Information

Family Physician: _____ Phone: _____

Other Medical Insurance: _____ Insurance Number: _____

In case of emergency, please notify:

Name: _____ Evening Phone: _____

Daytime Phone: _____ Cell Phone: _____

Alternate Contact:

Name/Relationship: _____ Evening Phone: _____

Daytime Phone: _____ Cell Phone: _____

Special Dietary Concerns: Yes No
please explain:

Atlantoaxial Instability Profile

Does this athlete have Down Syndrome? Yes No

If the athlete has Down Syndrome, he/she must be tested for Atlantoaxial Instability at initial registration. The results, along with the physician's signature, must be included with the original registration form before the athlete may be permitted to participate in training.

Date of X-ray testing for Atlantoaxial Instability: _____

Results of X-ray: Positive Negative

If the athlete has Down Syndrome and has tested positive for Atlantoaxial Instability, the athlete cannot participate in Soccer, High-Jump, Pentathlon, Swimming (NOTE: only the butterfly stroke and/or diving starts are prohibited.), Gymnastics, Alpine Skiing, Floor Hockey, or Equestrian without a copy of the X-ray results accompanied by a letter from a licensed medical professional stating that the associated risks have been explained to the athlete and parent/guardian/caregiver, as well as, a letter from the athlete's parents or caregivers that acknowledge and accept the associated risks (Special Olympics Saskatchewan Policy Manual).

* records will be stored at the Provincial office

Medical History Please indicate if the athlete has any of the following conditions:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> back/neck disorder | <input type="checkbox"/> fainting | <input type="checkbox"/> infectious disease | <input type="checkbox"/> surgery |
| <input type="checkbox"/> blood transfusions | <input type="checkbox"/> gastro-intestinal disorder | <input type="checkbox"/> kidney disorder | <input type="checkbox"/> thyroid disorder |
| <input type="checkbox"/> bowel/urinary disorder | <input type="checkbox"/> head injury | <input type="checkbox"/> nose bleeds | <input type="checkbox"/> uses mobility aid |
| <input type="checkbox"/> contacts/glasses | <input type="checkbox"/> hearing aid(s) | <input type="checkbox"/> psychiatric disorder | <input type="checkbox"/> other condition or information |
| <input type="checkbox"/> dental appliances | <input type="checkbox"/> hearing disorder | <input type="checkbox"/> respiratory problems | |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> heart condition | <input type="checkbox"/> seizures | |

If Seizures, Controlled: Yes No

Any other conditions or information that you feel a coach or ambulance attendant needs to know. Please ensure the coach is aware of any medications that the athlete is on and what medical condition it is treating.

Other: allergies, medications, behavioral concerns

Athlete Waiver

PRIVACY POLICY

Special Olympics Saskatchewan (SOS) will protect your personal information and adhere to all legislative requirements with respect to privacy. We use your personal information to provide services and to keep you informed and up to date on the activities of SOS, including programs, services, special events, funding requirements and media. I, the undersigned athlete, parent and/or legal guardian of the above named athlete, warrant you that the athlete is eligible to participate with SOS. On behalf of the athlete and myself, I acknowledge that facilities used for SOS programs will be done so at the user's own risk and I, hereby release, discharge and indemnify SOS/Special Olympics Canada (SOC) from all liability for injury to person or damage to property of myself and entrant. In permitting the athlete to participate, I am specifically granting permission to you to use the likeness, voice and words from the athlete in television, radio, films, newspaper, magazine, and other media, and in any form not heretofore described, for the purpose of advertising or communicating the purposes and activities of SOS/SOC, and in appealing for funds to support such activities. I authorize SOS to act in the best interest on behalf of the athlete to ensure that necessary care and treatment is provided in case of an emergency. All of the above information I have given in support of this registration is true and accurate to the best of my knowledge. I understand that any and all references to SOS/SOC include and apply equally to SOS accredited zones/communities, as well as to the Provincial and Territorial Chapters of SOC.

OATH OF CONFIDENTIALITY

As a registered member of Special Olympics Saskatchewan (SOS), I hereby consent that I will not disclose any personal information that I may have access to other than for the purposes of conducting the business of SOS/Special Olympics Canada.

Signature

Date

Signature of Witness

Date