ATHLETE INFORMATION & MEDICAL HISTORY FORM

Date completed (MM/DD/YY) : _____/_____/_____ Last completed: ☐ 1 yr ☐ 2 yrs ☐ 3 yrs

1. Personal Information

SOO Registration Number (if known): ______________________________

First Name: ________________________ Initial: ____ Last Name: ______________________________

Address: ____ Apt / Unit #: ____________

City: __________________________ Province: **ONTARIO** Postal Code: _____________

Home Phone Number: (_____) ________________ Cell Phone Number: (_____) ________________

E-mail (athlete): ____

E-mail (caregiver): ____

_______/_______/_______
Date of Birth (MM/DD/YY) *optional

Gender *optional: ☐ Male ☐ Female

____
OHIP Number *This information is provided voluntarily and not required for the completion of this form

Special Olympics Ontario

2. Race, Indigenous identity and Socio Economic information

Special Olympics is committed to diversity, inclusion and equity. As part of this commitment, we are collecting information from our athletes and volunteers to provide us with a better understanding of who is accessing our programming, who may be facing barriers to access, and for what reasons. We will use the collected information to help address these barriers.

Below are questions about your racial or ethnic background and your socio-economic status (income). Answering these questions is optional and will have no impact on your registration status. Providing this information will help Special Olympics make sure our programs are as accessible and available to as many people as possible. If you have any questions about the collection of this information please email: equity@specialolympicsontario.com

a. Which of the following best describes your racial or ethnic group? (optional):	
☐ Asian – East (e.g. Chinese, Japanese, Korean)	☐ Latin American (e.g. Argentinean, Chilean, Salvadoran)
☐ Asian – South (e.g. Indian, Pakistani, Sri Lankan)	☐ Métis
☐ Asian - South East (e.g. Malaysian, Filipino, Vietnamese)	☐ Middle Eastern (e.g. Egyptian, Iranian, Lebanese)
☐ Black – African (e.g. Ghanaian, Kenyan, Somali)	☐ White - European (e.g. English, Italian, Portuguese, Russian)
☐ Black – Caribbean (e.g. Barbadian, Jamaican)	☐ White - North American (e.g. Canadian, American)
☐ Black - North American (e.g. Canadian, American)	☐ Mixed heritage (e.g. Black - African & White - North American) Please specify: ____________________
☐ First Nations	☐ Other(s): Please specify: ____________________
☐ Indian - Caribbean (e.g. Guyanese with origins in India)	☐ Do not know
☐ Indigenous/Aboriginal - not included elsewhere	☐ Prefer not to answer
☐ Inuit	*Adapted from materials developed by Health Equity Office, Sinai Health System for the "Toronto Central LHIN Measuring Health Equity" project www.torontohealthequity.ca

b. Do you receive social assistance for disability? (e.g. Ontario Disability Support Program (ODSP); British Columbia Employment & Assistance for Persons with Disabilities, Saskatchewan Assured Income for Disability-SAID, Prince Edward Island-AccessAbility Supports)

☐Yes ☐No ☐Prefer not to answer

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3. Living Arrangement

☐ Independent ☐ With Family ☐ Group Home Other: ____________________

4. Emergency Contact(s)

1. Name: ______________________________ Relationship to Athlete: ____________________

Home Phone Number: (____) ____________________ Cell Phone Number: (____) ____________________

2. Name: ______________________________ Relationship to Athlete: ____________________

Home Phone Number: (____) ____________________ Cell Phone Number (____) ____________________

5. Medical Contact(s)

Family Doctor (please print name): ____

Phone Number: (____) ____________________

5. Medical History

Please check Yes (Y) or No (N) for all areas

If yes, please specify in the boxes below: Food Allergies, Sting/Bite Allergies, Medicine Allergies

Y	N	
☐	☐	Food Allergies
☐	☐	Sting/Bite Allergies
☐	☐	Medicine Allergies
☐	☐	Do you carry an epi-pen?
☐	☐	Asthma
☐	☐	Do you carry an inhaler?
☐	☐	Blindness or Visual Problems
☐	☐	Bone or Joint Problems
☐	☐	Chest Pain
☐	☐	Concussion or Serious Head Injury
☐	☐	Diabetes
☐	☐	Down Syndrome
☐	☐	Atlanto-Axial Instability
☐	☐	Easy Bleeding
☐	☐	Emotional/Psychological/ Behaviour Problems

Y	N	
☐	☐	Hearing Loss/Hearing Aid

Y	N		Y	N
☐	☐	Major Surgery or serious illness	☐	
☐	☐	Heat Stroke/Exhaustion	☐	
☐	☐	High Blood Pressure	☐	
☐	☐	Medications (if yes, please indicate below)	☐	
☐	☐	Non-Verbal		
☐	☐	Seizures/Epilepsy/Fainting Spells If yes, date of last episode ____/____/____ (MM/DD/YY)		
☐	☐	If yes, commonly reoccurring		
☐	☐	Requires Assistance		
	☐	Uses Wheelchair		
	☐	Other: ____________________		

If you answered yes to any questions above, please elaborate in the boxes below:

Please explain any medical issues and how to address them (eg. List any allergies, response to seizures, ect., medications required for specific circumstances

Please indicate any information that will benefit the athlete/coach training relationship (eg. Behaviour management, communications, limitations, ect.)

6. <u>Medications</u> (Please attach any additional information necessary)

Does athlete self-medicate? Yes ☐ No ☐

Medication Name	Dosage	Times per Day

Medication Name	Dosage	Times per Day

Medication Name	Dosage	Times per Day

Medication Name	Dosage	Times per Day

Medication Name	Dosage	Times per Day

Important: I understand that the information contained in this form may be deemed confidential. I affirm that I have read the above and that the information I have given is true and complete. This form must be completed and signed in order to participant in any practice or sporting event

Name (printed): ________________________________ Signature:____________________________________

Relationship to Athlete:_____________________________________ Date: ____________________________

Important: Information must be confirmed by the coaching staff or manager before the first practices of the year.

Date Information Confirmed Correct	Date Information Revised	Athlete/Guardian Initials	Coach/Manager Initials

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