Special Olympics Ontario

Athlete Profile – LaSalle-Windsor

Name			Tshirt rec'd Y / N
Address			
		Postal Code	
Phone		Male	Female
Date of Birth	Month	Day	Year
E Mail Address			
Living Arrangement – Please Check			
Parental Home	Group Home	Apartment Living	Foster Home

Emergency Contact:

Name	
Relationship to Athlete	
Address	
Home Phone	Work Phone
Cell Phone	Email

Does the athlete attend School	Yes	No
School / Worksite	Phone	
Can your photograph be used for media purposes as mentioned on the SOO Registration Form?	Yes	No

Medical Contact(s)

Family Doctor (please print name)_____

Phone Number (___)_____

Please ensure all medications are packaged, clearly labelled and indicate daily dosage with instructions when athlete is at a sporting event. Please ensure athlete has health card number with them at events.

Medical History

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

If yes, please specify in the boxes below

Y	N		Y	N	
☐	☐	Food Allergies	☐	☐	Emotional/Psychological/ Behaviour Problems
☐	☐	Sting/Bite Allergies	☐	☐	Hearing Loss/Hearing Aid
☐	☐	Medicine Allergies	☐	☐	Major Surgery or serious illness
☐	☐	Do you carry an epi-pen?	☐	☐	Heat Stroke/Exhaustion
☐	☐	Asthma	☐	☐	High Blood Pressure
☐	☐	Do you carry an inhaler?	☐	☐	Medications (if yes, please indicate below)
☐	☐	Blindness or Visual Problems	☐	☐	Non-Verbal
☐	☐	Bone or Joint Problems	☐	☐	Seizures/Epilepsy/Fainting Spells
☐	☐	Chest Pain			If yes, date of last episode ____/____/____ (MM/DD/YY)
☐	☐	Concussion or Serious Head Injury	☐	☐	If yes, commonly reoccurring
☐	☐	Diabetes	☐	☐	Requires Assistance
☐	☐	Down Syndrome	☐	☐	Uses Wheelchair
☐	☐	Atlantoaxial Instability	☐		
☐	☐	Easy Bleeding			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, etc., medications required for specific circumstances

Medications (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

Does the athlete have Down Syndrome	Yes	No

If yes, indicate date and result of X-ray for Atlanto-Axial Instability:

Month	Day	Year
Result Please Check	Positive	Negative

Disability Intellectual/Developmental Disability (diagnosis)	**Please Provide Details**
Physical Concerns	**Please Provide Details**
SUPERVISON: Does the athlete require Support Staff?	

Yes	No

Does the athlete exhibit any behavioural concerns that we need to be aware of?

Yes	No

If yes, suggested interventions?

Does the athlete need supervision and/or support with spending money?

Yes	No

If yes, please explain:

Special Olympics Ontario is committed to protecting the privacy of our athletes. Please be advised the information on this profile may be used for emergency purposes when an athlete competes at a sporting event. The mailing information will be used to communicate with the athlete, but will not be shared with any other organization.

Signature of Athlete / Guardian	
Print Name	
Signature of Witness	
Print name	
Date	