

ATHLETE REGISTRATION FORM (2025 / 2026)

SOBC Local*: _____

☐ Returning Athlete ☐ New Athlete

*Local is the community you wish to participate in

ATHLETE INFORMATION

First Name:	Last Name:
Date of Birth (yyyy/mm/dd):	Gender:
Personal Email Address:	
Home Phone:	Cell Phone:

TERMS AND CONDITIONS



The Special Olympics Terms and Conditions are basic rules for participation in Special Olympics. The full wording of the Terms and Conditions can be found here:

<https://www.specialolympics.ca/british-columbia/terms-and-conditions-participation>

Athletes/volunteers must agree to the Terms and Conditions to participate in Special Olympics.

By signing below you agree to the Special Olympics Terms and Conditions on behalf of yourself or your child/ward.

Part 1: Criminal Record

Has the person who is being registered or enrolled ever been charged with or convicted of any criminal offence?

☐ Yes ☐ No

Part 2: Media Release Opt-in / Opt-out:

I allow Special Olympics to use my/their picture, words or voice in promotional media

☐ Yes ☐ No

Part 3:

I agree to the Special Olympics Terms and Conditions and attest that my answers on the media release opt-in/opt-out and criminal record are true

☐ Yes

PRIMARY/ HOME ADDRESS

Street Address:		City:
Province:	Country:	Postal Code:
Athlete Living Situation: <input type="checkbox"/> Parent / Guardian <input type="checkbox"/> Caregiver <input type="checkbox"/> Group Home <input type="checkbox"/> Independent		

MEDICAL INFORMATION

Health Card #:	Physician's Name:	Physician Phone:
Does Athlete Take Any Medication? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please provide Medication Details and Dosage) (Please provide medication details in CAPITAL LETTERS or attach a printed copy)		
Medication Self Administered: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Seizures: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please seizure type, frequency, and treatment plan)		
Allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please provide Allergy Details, such as foods, drugs, or other)		
Allergy Treatment: (ie. does the athlete carry an epi-pen or medication in the event of anaphylaxis?):		

Down Syndrome: <input type="checkbox"/> Yes <input type="checkbox"/> No	AAXray Date:	AAXray Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
Medical Conditions: <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Depression <input type="checkbox"/> Epilepsy <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes (If yes, please indicate treatment plan in Other Medical Notes below) <input type="checkbox"/> Other (_____)		
Any additional medical or behavioral information that may help us support the athlete at their best: 		
Health Devices: (ie. Hearing aids, glasses, contacts...etc)	Dietary Requirements: (ie. Gluten-free, lactose-free...etc)	
EMERGENCY CONTACT INFORMATION		
The Primary Contact will be the first person called in case of an emergency The Secondary Contact will be the second person called or if Primary Contact cannot be reached		
Primary Contact Name:		
Relationship to Athlete: <input type="checkbox"/> Parent/ Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Friend <input type="checkbox"/> Relative		
Primary Phone:	Cell Phone:	
Secondary Contact Name:		
Relationship to Athlete: <input type="checkbox"/> Parent/ Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Friend <input type="checkbox"/> Relative		
Primary Phone:	Cell Phone:	
PARENT / GUARDIAN INFORMATION (only required if athlete is under 19 years of age or has a legal guardian)		
Name:	Relationship to Athlete:	
<input type="checkbox"/> Same Contact Info as Athlete (please list anything different below)		
Street Address:		City:
Province:	Country:	Postal Code:
SPORTS PROGRAMS (indicate sports athlete would like to register for – sports offered will vary by Local)		
Winter: <input type="checkbox"/> 5-Pin Bowling <input type="checkbox"/> Alpine Skiing <input type="checkbox"/> Cross Country Skiing <input type="checkbox"/> Curling <input type="checkbox"/> Figure Skating <input type="checkbox"/> Floor Ball <input type="checkbox"/> Snow Shoeing <input type="checkbox"/> Speed Skating	Summer: <input type="checkbox"/> 10-Pin Bowling <input type="checkbox"/> Bocce <input type="checkbox"/> Basketball <input type="checkbox"/> Golf <input type="checkbox"/> Powerlifting <input type="checkbox"/> Rhythmic Gymnastics <input type="checkbox"/> Soccer <input type="checkbox"/> Softball <input type="checkbox"/> Swimming <input type="checkbox"/> Track & Field	Other Programs: <input type="checkbox"/> Active Start (ages 2-6) <input type="checkbox"/> FUNdamentals (ages 7-11) <input type="checkbox"/> Club Fit (Fitness) <input type="checkbox"/> Athlete Leadership Program
By filling in my name below, I acknowledge that the information provided on this form is correct to the best of my knowledge and I will update this information should it change		
ATHLETE SIGNATURE (if 19+ years of age)		
Athlete Signature:		Date:
PARENT/GUARDIAN SIGNATURE (required if athlete is under 19 years of age or requires a legal guardian to sign legal documents on their behalf)		
Parent/Guardian Signature:		Date:
Print Name:		Email: