ATHLETE REGISTRATION

Special Olympics Saskatchewan

Profile Information

Name: _____ *
First Last

*Program Enrollment Information

*(Please note that **not all sports listed** are offered in every community program)*
Please indicate *(check box)* the sport(s) the athlete will be participating in for the current program year:

- ☐ 10-Pin Bowling
- ☐ 5-Pin Bowling
- ☐ Alpine Skiing
- ☐ Aquatics
- ☐ Athletics
- ☐ Bocce Ball
- ☐ Basketball* *Team:* ____
- ☐ Curling
- ☐ Equestrian
- ☐ Figure Skating
- ☐ FITNESS
- ☐ Floor Hockey* *Team:* ____
- ☐ Golf
- ☐ Power-lifting
- ☐ Rhythmic Gymnastics
- ☐ Snowshoeing
- ☐ Soccer* *Team:* ____
- ☐ Softball* *Team:* ____
- ☐ Speed Skating
- ☐ Synchro-Swimming
- ☐ Walking Program

Community: _____ **Sex:** ❒ **Male** ❒ **Female** ❒ **X** **Gender Identity:** _____

Birth Date (MM/DD/YYYY): _____ **Portal E-Mail:** _____ ❒ **Honorary Life Member**

Have you ever been charged/convicted of any criminal offence as outlined in the waiver? ❒ No ❒ Yes

Self-Declaration: Do you identify as an Indigenous? Do you identify as an Indigenous person that is First Nations (North American Indian), Metis, or Inuk (Inuit) *Includes Status and Non-Status Individuals*

❒ First Nations (North American Indian) ❒ Metis ❒ Inuk (Inuit) ❒ Prefer not to say ❒ No

Contact Information

Email: _____ **Home Phone:** _____
EMAIL PROVIDED WILL BE HOW S.O.R. PROVIDES INFORMATION

Mobile Phone: _____ **Business Phone:** _____ **Primary:** ❒ Home ❒ Mobile ❒ Business

Communication & Preferences

Primary Language Preference: ❒ English ❒ French **Contact Preference:** ❒ Allowed ❒ Not Allowed
Preferred Method of Contact: ❒ Any ❒ Email ❒ Phone ❒ Mail

Do you have seizures? ❒ Yes ❒ No Seizures Controlled By: _____
Do you have allergies? ❒ Yes ❒ No How do you treat your allergies? _____

Dietary Restrictions: Please write '*None*' or '*N/A*' if you do have any dietary restrictions

Medical Notes: 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.

Emergency Contact

***Minimum of at least (1) contact must be provided**

Name (1): _____ * Relationship: _____
First Last

Primary Phone: _____ Secondary Phone: _____

Name (2): _____ Relationship: _____

Primary Phone: _____ Secondary Phone: _____

Living Situation:

- ❒ Independent
- ❒ With Parent(s)
- ❒ Foster Parents/Caregiver/Guardiar
- ❒ Group Home
- ❒ Supported Independent Living
- ❒ With Family – Not Parents
- ❒ Institution
- ❒ Prefer not to say

Group Home Affiliate: _____

Important Information: Please be aware that additional Community fees may apply. Contact your community for further details on what is needed to complete your enrollment.

Waiver

To complete the process of registration on a paper form, please complete and submit the following form:

❒ **Attached Participation Waiver and Promotional Media Opt in or Opt out form**

The Participant Waiver, which includes the Consent to use Personal Information and Privacy Policy Confirmation, and Code of Conduct and Ethics components is MANDATORY in order to participate in Special Olympics programming. For the Promotional Media portion, participants may "Opt in" or "Opt out" of being included in promotional media relating to Special Olympics.

Primary Address

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

Secondary Address

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

Medical Information

Health Card Number: _____ **Card Expires On (MM/DD/YYYY):** _____

Province Issued By: ____ **Doctor's Name:** _____ **Doctor's Phone:** _____

Medications & Dosages: Please write '*None*' or '*N/A*' if you do not take any medications

Medical Conditions

Please indicate *(check box)* if the athlete has any of the following conditions:

- ☐ Serious Illness
- ☐ Arthritis
- ☐ COPD
- ☐ Asthma
- ☐ Depression
- ☐ Fibromyalgia
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Fetal Alcohol Syndrome
- ☐ High Blood Pressure
- ☐ Epilepsy

☐ Other Condition(s): _____

Do you (this athlete) have Down Syndrome? ❒ Yes ❒ No

If the athlete has Down Syndrome, they need to 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: *(MM/DD/YYYY)*:

Results of X-Ray: ❒ Negative ❒ Positive

Physician Name: _____ Signature: _____

Date:

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).