

Athlete Annual Renewal Form

Required annually for all athletes participating in Special Olympics.

Special Olympics



Local Special Olympics Program: _____

Athlete Information - To be completed by the athlete or parent/guardian/caregiver.

First name: _____ Last name: _____ Middle name: _____

Date of birth (dd/mm/yyyy): ____/____/____ Gender: Female Male Prefer not to answer

Home address: _____ Country: _____

Phone number: _____ Mobile Landline

Office Use Only:
Athlete ID: _____

Have there been any changes to your health history in the past year? Yes No

If yes, please complete the health history section. If no, please complete the signature section.

Health History

Health and/or mobility aids the athlete possesses and may use during Special Olympics participation.	<input type="checkbox"/> CPAP	<input type="checkbox"/> Eyeglasses/Contacts/Protective Eyewear	<input type="checkbox"/> Implantable Device for Seizure
	<input type="checkbox"/> Prosthetics	<input type="checkbox"/> Hearing Aid/Communication Device	<input type="checkbox"/> Wheelchair/Walker/Leg Braces
	<input type="checkbox"/> Dentures	<input type="checkbox"/> Pacemaker/Implanted Defibrillator	<input type="checkbox"/> VP Shunt
	<input type="checkbox"/> None	<input type="checkbox"/> Other: _____	

List any allergies and/or dietary requirements:

General Health Questions:

Do you have a heart condition?	<input type="radio"/> Yes <input type="radio"/> No	Do you have asthma?	<input type="radio"/> Yes <input type="radio"/> No
Have you ever had a head injury or concussion?	<input type="radio"/> Yes <input type="radio"/> No	Do you have diabetes?	<input type="radio"/> Yes <input type="radio"/> No
If yes, number of head injury/concussion(s): _____		Do you have a vision impairment?	<input type="radio"/> Yes <input type="radio"/> No
Date of most recent head injury/concussion: _____		Do you have a hearing impairment?	<input type="radio"/> Yes <input type="radio"/> No
Do you have a bleeding disorder?	<input type="radio"/> Yes <input type="radio"/> No	Do you have sickle cell disease?	<input type="radio"/> Yes <input type="radio"/> No
Do you have epilepsy or any type of seizure disorder?			<input type="radio"/> Yes <input type="radio"/> No
Do you have behavioral, mental health, and/or sensory conditions that could impact your/other's participation?			<input type="radio"/> Yes <input type="radio"/> No

If yes to any of the above general health questions, please provide additional details:

Medication and Treatment

Have there been any changes to your prescriptions, over-the-counter medications, or treatments? Yes No

If yes, please list below:

Medication, Vitamin, or Supplement Name	Dosage	Times per day	Medication, Vitamin, or Supplement Name	Dosage	Times per day

Do you have severe allergies that requires the use of an EpiPen? Yes No

If yes, please specify if it is to any of the following:

Insect stings Medication/drugs Food Latex Other (please specify): _____

I certify the information provided on this form is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Is this form being completed by someone other than the athlete? Yes No

If yes, please select the relationship to athlete:

Parent/Guardian Caregiver/Other Family Member Healthcare Provider Other: _____