

ATHLETE REGISTRATION FORM (2021 / 2022)

SOBC Local: SUNSHINE COAST

Returning Athlete New Athlete

ATHLETE INFORMATION		
First Name:		Last Name:
Date of Birth (mm/dd/yyyy):		Gender:
Athlete Email:		
Alternate Email:		
Street Address:		City:
Postal Code:	Home Phone:	Cell Phone:
Athlete Living Situation: <input type="checkbox"/> Parent / Guardian <input type="checkbox"/> Caregiver <input type="checkbox"/> Group Home <input type="checkbox"/> Independent		
SPORTS PROGRAMS (indicate sports athlete would like to register for)		
<input type="checkbox"/> Basketball <input type="checkbox"/> Bocce <input type="checkbox"/> Curling <input type="checkbox"/> Golf <input type="checkbox"/> Soccer <input type="checkbox"/> Softball	<input type="checkbox"/> Swimming <input type="checkbox"/> Track & Field <input type="checkbox"/> Active Start (ages 2-6) <input type="checkbox"/> FUNdamentals (ages 7-12) <input type="checkbox"/> Club Fit (Fitness)	
PARENT / GUARDIAN / CAREGIVER INFORMATION (required if athlete is under 19 or otherwise has a legal guardian)		
Name:		Relationship to Athlete:
<input type="checkbox"/> Same Contact Info as Athlete (please list anything different below)		
Street Address:		City:
Postal Code:	Home Phone:	Cell Phone:
Email:		
EMERGENCY CONTACT INFORMATION		
Primary Contact Name:		
Relationship to Athlete: <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Friend <input type="checkbox"/> Relative		
Home 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		
Home Phone:		Cell Phone:

ATHLETE NAME: _____ SOBC LOCAL: SUNSHINE COAST

MEDICAL INFORMATION (if more space is needed, please attached a separate sheet)

Health Card #:

Physician Name:

Physician Phone:

Medications & Dosages (please list) Self-Administered Yes No

Seizures: Yes No If yes, please indicate seizure type, frequency, and treatment plan:

Allergies: Yes No If yes, please provide Allergy Detail (including food, drugs, or other)

Allergy Treatment (ie. does the athlete carry an epi-pen, medication, etc.)

Down Syndrome Yes No

AAXray Date:

AAXRay Result: Positive Negative

Medical Conditions:

- Arthritis Asthma Depression Epilepsy High Blood Pressure
 Diabetes (if yes please indicate treatment below in medical notes)
 Other (if yes please provide details below in medical notes)

Health Devices (please list if athlete has glasses, contacts, hearing aids, etc.):

Dietary Requirements (please indicate any specific dietary requirements i.e., gluten or lactose free):

Medical Notes (please include any additional information):

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 or over)

Athlete Signature:

Date:

PARENT/GUARDIAN SIGNATURE (required for athlete under 19 or who requires legal guardian to sign legal documents)

Parent/Guardian Signature:

Date:

Printed Name:

Relationship to Athlete:

****If filling in and submitting the form online, you may type your name in the signature line****