**ATHLETE REGISTRATION FORM (2023 / 2024)**

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SOBC Local:

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**\*\*Local is the community you wish to participate in**

**Returning Athlete**

**New Athlete**

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| **ATHLETE INFORMATION** |
| **First Name:** | **Last Name:** |
| **Date of Birth (mm/dd/yyyy):** | **Gender:** |
| **Athlete Email for Portal Account:** |
| **(Optional)Parent/Guardian/Caregiver Email:** |
| **Street Address:** | **City:** |
| **Postal Code:** | **Cell Phone:** | **Home Phone:** |
| **Athlete Living Situation:** ☐ **Parent / Guardian** ☐ **Caregiver** ☐ **Group Home** ☐ **Independent** |
| **SPORTS PROGRAMS** (indicate sports athlete would like to register for – sports offered will vary by Local) |
| * 5-Pin Bowling
* Basketball
* Bocce
* Curling
 | * Floor Hockey
* Golf
* Powerlifting
* Rhythmic Gymnastics
* Soccer
* Softball
 | * Speed Skating
* Snowshoeing
* Swimming
* Track & Field
* Active Start (ages 2-6)
* FUNdamentals (ages 7-11)
* Sport Start (ages 12-16)
* Club Fit (Fitness)
* Athlete Leadership Program
 |
| **PARENT / GUARDIAN / CAREGIVER INFORMATION** (required if athlete is under 19 or otherwise has a legal guardian) |
| **Name:** | **Relationship to Athlete:** |
| * **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:** ☐ **Parent/Guardian** ☐ **Spouse** ☐ **Friend** ☐ **Relative** |
| **Home Phone:** | **Cell Phone:** |
| **Secondary Contact Name:** |
| **Relationship to Athlete:** ☐ **Parent/Guardian** ☐ **Spouse** ☐ **Friend** ☐ **Relative** |
| **Home Phone:** | **Cell Phone:** |

**ATHLETE NAME: SOBC LOCAL:**

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| **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)
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| **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\*\*