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



☐

SOBC Local:



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

**Returning Athlete**

**New Athlete**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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\*\*