

SPECIAL OLYMPICS AREA M NEW MEDICAL UPDATE

IT IS IMPORTANT THAT WE HAVE CORRECT INFORMATION ON FILE AT ALL TIMES. PLEASE COMPLETE THIS FORM AND RETURN IT TO YOUR COACH AS SOON AS POSSIBLE.

SPORT _____

NAME _____ **T-shirt Size** _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (DAY) _____ **(EVENING)** _____

Emergency contact

NAME _____ **Relationship** _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (DAY) _____ **(EVENING)** _____

CELL PHONE _____ **OTHER** _____

EMAIL ADDRESS _____

Athlete medical details

MEDICATIONS no yes *If yes, please complete the details on the back of this form*

SEIZURES no yes **IF YES, PLEASE DESCRIBE WHAT TRIGGERS THE SEIZURE.**

DESCRIBE THE SEIZURE ACTIVITY DURING AND FOLLOWING THE SEIZURE:

This added information will help us in caring for your athlete if a seizure should occur.

SIGNATURE _____ **DATE** _____

PARENT/GUARDIAN _____

