ATHLETE RENEWAL REGISTRATION FORM

Special Olympics New Hampshire

Local Program: _____

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

First Name: _____ Middle Name: _____ Last Name: _____

Preferred Name: _____ Gender: ◯ Female ◯ Male ◯ Other Gender Identity

Date of Birth: _____ T Shirt Size (XS – 5XL): _____ ◯ Youth ◯ Adult

Email: _____ Phone: _____ ◯ Mobile ◯ Landline

Home Address: _____

City: _____ State: _____ Zip Code: _____

Is the athlete his or her own guardian? ◯ **Yes** ◯ **No**

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.	☐ CPAP ☐ Prosthetics ☐ Dentures ☐ None	☐ Eyeglasses/Contacts/Protective Eyewear ☐ Hearing Aid/Communication Device ☐ Pacemaker/Implanted Defibrillator ☐ Other: _____	☐ Implantable Device for Seizure ☐ Wheelchair/Walker/Leg Braces ☐ VP Shunt
List any allergies and/or dietary requirements:			

General Health Questions:

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

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: _____	

PO BOX 3598 Concord, NH 03302 **Tel** 603 624 1250 **Fax** 6036244911 SpecialOlympics@sonh.org