

# ATHLETE REGISTRATION FORM



Special Olympics ND Program: \_\_\_\_\_

Are you a new athlete to Special Olympics or Re-Registering?  New Athlete  Re-Registering

## ATHLETE INFORMATION

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Last Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_\_  Female  Male  Other Gender Identity

Race/Ethnicity: \_\_\_\_\_  Prefer not to answer

- American Indian/Alaskan Native  Asian American  More than one Race  
 Black or African American  Native Hawaiian or Other Pacific Islander  
 White or Caucasian  Hispanic or Latinx

Language(s) Spoken in Athlete's Home (Optional): Check all that apply  
 English  Spanish  Other (please list): \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Sports/Activities: \_\_\_\_\_

Name of School you attend \_\_\_\_\_ Graduation Date \_\_\_\_\_

Does the athlete have the capacity to consent to medical treatment on his or her own behalf?  Yes  No

## PARENT / GUARDIAN INFORMATION (required if minor or otherwise has a legal guardian)

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Same Contact Info as Athlete

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION

Same as Parent/Guardian

Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

## PHYSICIAN & INSURANCE INFORMATION

Physician Name: \_\_\_\_\_

Physician Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Insurance Policy Number: \_\_\_\_\_

Insurance Group Number: \_\_\_\_\_