Name :__________________________Birthdate:_________________

Address: ____

Postal Code: _________________ Phone: __________________

Best Contact: ___________________Phone: ________________

Emergency Contact: ____________________________________

Phone: _________________ Relationship: __________________

Medical Concerns: ______________________________________

Medical Number (optional) ______________ & PIN _____________

Down Syndrome:Yes____ Atlantoaxial Dislocation: Pos___Neg___

Seizures: Yes No If yes, Controlled: Yes No

Type of Seizure: ________________ Duration: __________

Hearing Impaired Yes No Visually Impaired: Yes No

Allergies: ____

____

Medication and Dosage: ________________________________

____

Behavioral Concerns: __________________________________

____

Recommended Actions: ____________________________________

____

Other Concerns: ____

____

Date Completed: _______________________________________

Reminder – if any information changes please complete another card.

Special Olympics Manitoba

Name :________________________Birthdate: __________________

Address: ____

Postal Code: _________________ Phone: _________________

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Special Olympics Manitoba

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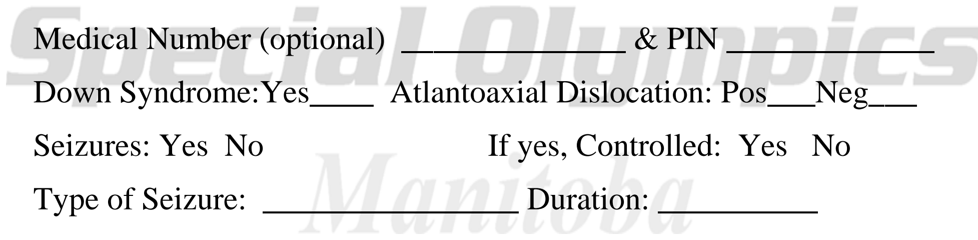

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Other Concerns: ____________________________________

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