VOLUNTEER REGISTRATION FORM (2021 / 2022)

Special Olympics British Columbia

SOBC Local**: KAMLOOPS

☐ Returning Volunteer ☐ New Volunteer

***Local is the community you wish to volunteer with*

VOLUNTEER INFORMATION		
First Name:	**Last Name:**	
Date of Birth (mm/dd/yyyy):	**Gender:**	
Email:		
Street Address:	**City:**	
Postal Code:	**Home Phone:**	**Cell Phone:**
NCCP# (if known):		

VOLUNTEER POSITIONS (please check the roles you are interested in)		
Sport Programs		
☐ 5-Pin Bowling ☐ 10-Pin Bowling ☐ Basketball ☐ Curling	☐ Floor Hockey ☐ Powerlifting ☐ Rhythmic Gymnastics	☐ Swimming ☐ Club Fit (Fitness)
I'm interested in role of ☐ Head Coach ☐ Assistant Coach ☐ Program Volunteer		
Administration Roles		
Executive ☐ Local Coordinator ☐ Treasurer ☐ Program Coordinator ☐ Volunteer Coordinator	☐ Fundraising Coordinator ☐ Public Relations Coordinator ☐ Registration Coordinator ☐ Secretary	**Other Roles** ☐ General Volunteer ☐ Event Volunteer ☐ Other
Additional comments on the volunteer roles you are interested in (optional)		

REFERENCES – Please provide two references (only required for NEW volunteers)		
Name:	**Phone:**	**Email:**
Relationship to volunteer applicant:		
Name:	**Phone:**	**Email:**
Relationship to volunteer applicant:		

Volunteer Name: ______________________ SOBC LOCAL: KAMLOOPS

PARENT / GUARDIAN INFORMATION (only required if volunteer is under 19)		
Name:	**Relationship to Volunteer:**	
☐ **Same Contact Info as Volunteer (please list anything different below)**		
Street Address:		**City:**
Postal Code:	**Home Phone:**	**Cell Phone:**
Email:		

EMERGENCY CONTACT INFORMATION	
Contact Name:	
Relationship to Volunteer: ☐ **Parent/Guardian** ☐ **Spouse** ☐ **Friend** ☐ **Relative**	
Home Phone:	**Cell Phone:**

MEDICAL INFORMATION	
Health Card #:	
Physician Name:	**Physician Phone:**
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 volunteer carry an epi-pen, medication, etc.):	
Medical Notes (please include additional information as applicable)	

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	
VOLUNTEER SIGNATURE **(if 19 years or over)**	
Volunteer Signature:	**Date:**
PARENT/GUARDIAN SIGNATURE **(required for volunteer who is under 19)**	
Parent/Guardian Signature:	**Date:**
Printed Name:	

****If filling in, and submitting the form online you may type your name in the signature line****