FORM 5



T

DELEGATE, COACH AND UNIFIED PARTNER REGISTRATION FORM

# Special Olympics Program: SOCT

**This Registration is for (check only one box):**

## Head of Delegation

* Assistant Head of Delegation
* Coach

🞏Unified Partner

* Additional Staff (AS)
* Medical Staff
  + Physician ☐ Physician Assistant
  + Nurse ☐ Other:

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PERSONAL INFORMATION** | | | | | | | | | |
| **First Name:** | | | | **Middle Name:** | | | | | |
| **Last Name:** | | | | **Preferred Name:** | | | | | |
| **Date of Birth (dd/mm/yyyy):** | | | | **□ Female ☐ Male** | | | | | |
| **Preferred Language (Optional): CHINESE** | | | | **Race/Ethnicity (Optional): CHINESE** | | | | | |
| **Address:** Rm. 213, 2F., No.55, Changji St., Datong Dist., Taipei City 103, Taiwan | | | | | | **City: TAIWAN** | | | |
| **State/Province: TAIWAN** | | | | **Country: TAIWAN** | | | | **Postal Code:10363** | |
| **Phone:** 886-2-25989571 | | | | **E-mail:** | | | | | |
| **Shirt Size:** | | | | | | | | | |
| **Passport Number:** | | | **Passport Country:** | | | | | | |
| **Passport Type:  Regular ☐ Diplomat ☐ Other:** | | | | | | | | | |
| **Date of Issue (dd/mm/yyyy):** | | | | | **Date of Expiration (dd/mm/yyyy):** | | | | |
| **EMERGENCY CONTACT INFORMATION** | | | | | | | | | |
| **Name: HAN HUANG** | | | | | | | | | |
| **Phone:886-22598-9571** | | | | **Relationship: FRIEND** | | | | | |
| **HEALTH INFORMATION\* This information is collected in case of medical emergency.** | | | | | | | | | |
| **Please indicate if you have any of the following and provide details:**   * Special Dietary Needs: ☐ Epilepsy or Seizure Disorder: * Allergies: ☐ Neurological Condition: * Assistive Devices: ☐ Diabetes: * High Blood Pressure: ☐ Sickle Cell Anemia/Trait: * Heart Conditions: ☐ Chronic Infection: * Asthma/Respiratory Condition: ☐ Missing Organ: * Mental Health Condition: ☐ Other Health Conditions: | | | | | | | | | |
| **Please use this space for any additional health information you want Special Olympics to know:** | | | | | | | | | |
| **PLEASE LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW** | | | | | | | | | |
| *Medication, Vitamin or Supplement Name* | *Dosage* | *Times per Day* | | | *Medication, Vitamin or Supplement Name* | | *Dosage* | | *Times per Day* |
|  |  |  | | |  | |  | |  |
|  |  |  | | |  | |  | |  |

**\***This health information is collected in case of medical emergency. Each participant is responsible to determine if he/she is physically able to participate.

G2 World Games Registration Forms – Updated March 2018