Special Olympics

DELEGATE, COACHES, AND ADDITIONAL STAFF REGISTRATION FORM

** (Asterisks) indicate mandatory fields for registration completion.*

DELEGATION:	
ROLE:	
Additional Staff ☐ **Assistant Head of Delegation** ☐	
Head Coach/ Coach ☐ **Head of Delegation** ☐ **Medical Staff** ☐	
Alternate Delegation Member ☐	
PERSONAL INFORMATION	
***Given/First Name:** Please use the same name as your passport	**Middle Name:** If you have a middle name on your passport, you must fill this out.
***Family/Last Name:** Please use the same name as your passport	***Date of Birth:** dd/mm/yyyy
In addition, do you have a different Birth Name stated on your Identification Document? ☐ **Yes** ☐ **No**	
If yes, please provide us with your Birth Name:	
***Gender:** Please check box ☐ **Female** ☐ **Male** ☐ **Diverse**	
***City/Place of Birth:**	
***Email:**	
***Mobile Country Code: +** Example: +23	***Mobile:** Example: 123 456 78 90
***Would you prefer to have a different first or last name on the credential?** ☐ **No** ☐ **Yes** If Yes: Preferred First name**:** Preferred Last name:	
☐ **Copy of the Credential Photo**	
***Country/Area of Residence:**	***State/Province/Region of Residence:**
***City of Residence:**	***Street & Number Address of Residence:**
***Postal Code:**	
***Native Language:**	
***Preferred Official SO Language:** Please choose from the following: Arabic ☐ Chinese ☐ English ☐ French ☐ German ☐ Russian ☐ Spanish ☐	

***Special Dietary Needs:**
Other Dietary Instructions:
PASSPORT INFORMATION & IDENTIFICATION DOCUMENT INFORMATION
☐ **Scanned Copy of the Passport ID Page** ☐
Identification Document: ☐ ID Card of other EU countries ☐ Passport ☐ Refugee Travel Document ☐ No identification Document
Country of the Identification Document:
***Do you require a visa to enter Germany?** ☐ No ☐ Yes
***If yes please add the Passport Expiry Date:** dd.mm.yyyy
***City where you would apply for a visa:**
EMERGENCY CONTACT INFORMATION
***Given/First Name:**
***Family/Last Name:**
***Phone Country Code: +** Example: +23 / ***Phone:** Example: 123 456 78 90
***Email:**
***Relationship:**
COACH CERTIFICATION
***Do you hold a coach certification?** ☐ **No** ☐ **Yes**
If Yes: ☐ **A certification from the Special Olympics (Program, Region, International)** ☐ **A certification from the Sport Federation or Governing Body (National, Regional, International)** ☐ **A certification from the Recognised Educational Institution**
***Special Olympics World Games Coach Preparation Course** ☐ **No** ☐ **Yes** You will need to upload your Certificate
***Special Olympics Unified Sports Coaching Course** ☐ **No** ☐ **Yes** You will need to upload your Certificate
HEAD OF DELEGATION
Have you completed the required on-line HODs/AHODs readiness training? ☐ **No** ☐ **Yes**

HEALTH INFORMATION

Allergies and Dietary Information

	No	Yes, if yes indicate details
*Any Known Allergies	☐	☐
• *Latex Allergy	☐	☐
• *Medication Allergy	☐	☐ _____
• *Insect Allergy	☐	☐ _____
• *Food Allergies	☐	☐ _____
*Special Dietary Needs	☐	☐ _____

Assistive Devices - Do you use any of the below? If **yes**, mark which ones. If **no**, leave blank.

☐ Brace	☐ Colostomy	☐ Communication Device
☐ C-PAP Machine	☐ Crutches/Walker	☐ Dentures
☐ Glasses/Contacts	☐ G-Tube/J-Tube	☐ Hearing Aid
☐ Implanted Device	☐ Inhaler	☐ Pacemaker
☐ Removable Prosthetics	☐ Splint	☐ Wheel Chair

Health Conditions

	No	Yes		No	Yes
*High Blood Pressure	☐	☐	*Diabetes	☐	☐
*Asthma	☐	☐	*Sickle Cell Anemia	☐	☐
*Sickle Cell Trait	☐	☐	*Easy Bleeding	☐	☐
*Vision Impairment	☐	☐	*Congenital Heart defect	☐	☐
*Hearing Impairment	☐	☐	*Medication	☐	☐

Infections and Epilepsy/Seizure Disorders	No	Yes, if yes indicate details
*Does this entrant have an acute infection?	☐	☐ _____
*Does this entrant have epilepsy or a seizure disorder?	☐	☐ _____
What is the type of seizure disorder?		_____

Health Conditions	No	Yes, if yes indicate details
*Chronic Infection	☐	☐ _____
*Mental Health Conditions	☐	☐ _____
*Missing Organ	☐	☐ _____
*Heart Conditions?	☐	☐ _____

Covid 19

***Did you have Covid -19 ?** ☐ No ☐ Yes If **yes** insert the date of positive test (dd/mm/yyyy)_____

***Tick the relevant box describe the level of symptoms athlete experienced**

☐ No symptoms

☐ Mild symptoms – cough, loss of taste, smell or tiredness that went away within two (2) weeks

☐ Moderate symptoms– shortness of breath on exertion, all over aches muscle pain

☐ Severe symptoms– hospitalized for any reason

Describe any health complications after COVID-19 infection/s :

Please use this space for any additional health information you want Special Olympics to know:

PLEASE LIST ANY MEDICATIONS, 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.

TRAVEL INFORMATION	
***Departing Country:** Arrival to Berlin	
***Departing City:** Arrival to Berlin	
***Arrival Date:** dd/mm/yyyy	***Arrival Time:** hh:mm
***Method of Arrival:** ☐ **Air** ☐ **Train** ☐ **Bus** ☐ **Self Driving**	
***Departure Travel Group:**	
***Departing Country:** Departure from Berlin	
***Departing City:** Departure from Berlin	
***Departure Date:** dd/mm/yyyy	***Departure Time:** hh:mm
***Method of Departure:** ☐ **Air** ☐ **Train** ☐ **Bus** ☐ **Self Driving**	