



DELEGATE, COACHES, AND ADDITIONAL STAFF REGISTRATION FORM

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

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:
*Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> X <input type="checkbox"/> Prefer Not to Say Please check box	
*Email:	
*Phone Country Code: + Example: +23	*Phone: Example: 123 456 78 90
*Delegation:	*Role:
<input type="checkbox"/> Credential Photo is attached	
*Country/Area of Residence:	*State/Region of Residence:
*City of Residence:	*Street Address:
Postal Code of Residence (Optional):	House/Building (Optional):
Native Language (Optional):	
*Preferred Official SO Language: Please choose of the following Spanish, English, French, Chinese, Russian, or Arabic.	
PARENT / GUARDIAN INFORMATION (required if minor or otherwise has a legal guardian)	
*Parent/Guardian Given/First Name:	
*Parent/Guardian Family/Last Name:	
*Parent/Guardian Phone Country Code: + Example: +23	*Parent/Guardian Phone: Example: 123 456 78 90
*Parent/Guardian Relationship: Example: Guardian, Mother, etc.	
*Parent/Guardian Country:	*Parent/Guardian Province/State:
*Parent/Guardian City:	*Parent/Guardian Street Address:
Parent/Guardian House/Building (Optional):	Postal Code (Optional):

EMERGENCY CONTACT INFORMATION		
<input type="checkbox"/> Is this person your guardian?		
*Emergency Contact Given/First Name:		
*Emergency Contact Family/Last Name:		
*Emergency Contact Phone Country Code: + Example: +23	*Emergency Contact Phone: Example: 123 456 78 90	
*Emergency Contact Email:	*Relationship:	
PASSPORT INFORMATION		
<input type="checkbox"/> Scanned Copy of the Passport ID Page		
*Citizenship:	*Country of Birth:	*City of Birth:
*Passport Number:		
*Issue Date:	*Expiry Date:	
*Country of Passport:		
*Passport Issuing Authority:		
*Country of Residence:		
*City where you will apply for a visa: Only for countries that need a visa.		

HEALTH INFORMATION					
Allergies and Dietary Information			Assistive Devices - Do you use any of the below? If yes, mark which ones. If no, leave blank.		
	No	Yes, if yes indicate details			
*Any Known Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Brace	<input type="checkbox"/> Colostomy	<input type="checkbox"/> Communication Device
• *Latex Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C-PAP Machine	<input type="checkbox"/> Crutches/Walker	<input type="checkbox"/> Dentures
• *Medication Allergy	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> Glasses/Contacts	<input type="checkbox"/> G-Tube/J-Tube	<input type="checkbox"/> Hearing Aid
• *Insect Allergy	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> Implanted Device	<input type="checkbox"/> Inhaler	<input type="checkbox"/> Pacemaker
• *Food Allergies	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/> Removable Prosthetics	<input type="checkbox"/> Splint	<input type="checkbox"/> Wheel Chair
*Special Dietary Needs	<input type="checkbox"/>	<input type="checkbox"/> _____			
Infections and Epilepsy/Seizure Disorders			No	Yes, if yes indicate details	
*Does this entrant have an acute infection?	<input type="checkbox"/>	<input type="checkbox"/>		_____	
*Does this entrant have epilepsy or a seizure disorder?	<input type="checkbox"/>	<input type="checkbox"/>		_____	
What is the type of seizure disorder?				_____	
Health Conditions			No	Yes	
*Heart Conditions	<input type="checkbox"/>	<input type="checkbox"/>	*High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
*Mental Health Conditions	<input type="checkbox"/>	<input type="checkbox"/>	*Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
*Missing Organ	<input type="checkbox"/>	<input type="checkbox"/>	*Asthma	<input type="checkbox"/>	<input type="checkbox"/>
*Chronic Infection	<input type="checkbox"/>	<input type="checkbox"/>	*Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>
			*Sickle Cell Trait	<input type="checkbox"/>	<input type="checkbox"/>
			*Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>

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

PLEASE LIST ANY MEDICATIONS, VITAMINS OR DIETARY SUPPLEMENTS BELOW

<i>Medication, Vitamin or Supplement Name</i>	<i>Dosage</i>	<i>Times per Day</i>	<i>Medication, Vitamin or Supplement Name</i>	<i>Dosage</i>	<i>Times per Day</i>

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

COVID-19 SUPPLEMENTAL INFORMATION

Please see the COVID-19 Supplemental Form for Medical Questions in Registration. Medical Forms must be signed by a doctor and reviewed by the Medical Staff of the Delegation.

SPORT & ACCOMMODATION

Sport:

You will only have one option depending on the sport you chose.

FORMS

Release Form

Likeness Release Form

TRAININGS (For Coaches, Head Coaches, AHODs, and HODs Only)

Have you completed trainings that are mandatory to you role?

HOD Readiness

World Games Coach Preparation Module

Unified Sports Coaching Training

TRAVEL INFORMATION

Copy of the confirmed ticket or invoice

Number of Suitcases/Luggage:

Number of Sports Equipment:

Number of Individuals using Mobility Assistance Devices:

ARRIVAL TO KAZAN

*Method of Arrival: <input type="checkbox"/> Air <input type="checkbox"/> Train <input type="checkbox"/> No Transfer Required	
*Departing City	
*Departing Country:	
*Flight/Train Reservation Number:	*Arrival Flight/Train Number:
*Arrival Date:	*Arrival Time:
*Airport/Station of Arrival	
ARRIVAL – TRANSIT THROUGH MOSCOW	
Will your flight include transit through Moscow? <input type="checkbox"/> Yes <input type="checkbox"/> No	
*Method of Arrival: <input type="checkbox"/> Air <input type="checkbox"/> Train <input type="checkbox"/> No Transfer Required	
*Departing City	
*Departing Country:	
*Arrival Flight Number:	
*Arrival Date:	*Arrival Time:
*Airport of Arrival:	
DEPARTURE FROM KAZAN	
*Method of Departure: <input type="checkbox"/> Air <input type="checkbox"/> Train <input type="checkbox"/> No Transfer Required	
*Departing City	
*Departing Country:	
*Departing Flight Number:	
*Departure Date:	*Departure Time:
*Airport of Departure:	
DEPARTURE – TRANSIT THROUGH MOSCOW	
Will your flight include transit through Moscow? <input type="checkbox"/> Yes <input type="checkbox"/> No	
*Method of Departure: <input type="checkbox"/> Air <input type="checkbox"/> Train <input type="checkbox"/> No Transfer Required	
*Departing City	
*Departing Country:	
Arrival Flight Number:	
*Arrival Date:	*Arrival Time:
*Airport of Arrival:	

MEDICAL STAFF INFORMATION (For Medical Staff Only)

*Medical Degree Type (e.g., MD, MBBS, RN, Physician Assistant):

*Year You Received Your Medical Degree:

*Clinical Focus/Health Care Profession (e.g. sports medicine, family medicine, etc):

*Medical License Number:

*License Issue Date (DD/MM/YYYY):

License Expiry Date (DD/MM/YYYY):

*Regulatory Authority that Granted Your License:

*Name of Employer/Organization:

*Type of Employer/Organization:

- Hospital
- University
- Clinic
- Other _____

- *Medical License *CV/Resume *HOD-signed Delegation Medical Staff Letter