DELEGATE, COACHES, AND ADDITIONAL STAFF REGISTRATION FORM

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

PERSONAL INFORMATION	
***Given/First Name:** Vorname Please use the same name as your passport	***Middle Name:** Weitere Namen (wie im Pass) If you have a middle name on your passport, you must fill this out.
***Family/Last Name:** Name Please use the same name as your passport	***Date of Birth:**
***Gender:** ☐ **Female** ■ **Male** ☐ **X** ☐ **Prefer Not to Say** Please check box	
***Email:**	
***Phone Country Code: +** +41 Example: +23	***Phone:** Example: 123 456 78 90 079....
***Delegation:** Switzerland	***Role:** HoD / A-HoD / Head Coach / Coach / AS - Coach
■ **Credential Photo is attached**	
***Country/Area of Residence:** Switzerland	***State/Region of Residence:** nichts angeben
***City of Residence:**	***Street Address:**
Postal Code of Residence (Optional):	**House/Building (Optional):**
Native Language (Optional): Italian, French, Swiss German oder anders	
***Preferred Official SO Language:** Please choose of the following Spanish, English, French, Chinese, Russian, or Arabic. English oder French	
PARENT / GUARDIAN INFORMATION (required if minor or otherwise has a legal guardian)	
***Parent/Guardian Given/First Name:** Dieser Teil leer lassen	
***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

☐ **Is this person your guardian?**

***Emergency Contact Given/First Name:** Eine Person angeben

***Emergency Contact Family/Last Name:**

***Emergency Contact Phone Country Code: +** Example: +23	***Emergency Contact Phone:** Example: 123 456 78 90
***Emergency Contact Email:**	***Relationship:** Bezug zu dieser Person

PASSPORT INFORMATION

Scanned Copy of the Passport ID Page

***Citizenship:**	***Country of Birth:**	***City of Birth:**

***Passport Number:**

***Issue Date:**	***Expiry Date:** Muss bis mindestens 10.08.2022 gültig sein!

***Country of Passport:**

***Passport Issuing Authority:** Siehe Pass 9 Behörde

***Country of Residence:**

***City where you will apply for a visa:**
Only for countries that need a visa. Bern, Switzerland

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

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**
*Heart Conditions	☐	☐ _____
*Mental Health Conditions	☐	☐ _____
*Missing Organ	☐	☐ _____
*Chronic Infection	☐	☐ _____

Die Kasten "Yes" brauchen zusätzliche Infos. Yes-Kasten nur dann ankreuzen, wenn nötig.

	No	**Yes**
*High Blood Pressure	☐	☐
*Diabetes	☐	☐
*Asthma	☐	☐
*Sickle Cell Anemia	☐	☐
*Sickle Cell Trait	☐	☐
*Easy Bleeding	☐	☐

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*
Persönliche Medikamente					

*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: Sportart angeben

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: 1	**Number of Sports Equipment:** Das wird später angegeben
Number of Individuals using Mobility Assistance Devices:	

ARRIVAL TO KAZAN

*Method of Arrival: ■ Air ☐ Train ☐ No Transfer Required	
*Departing City Dieser Teil leer lassen	
*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? ☐ Yes ■ No	
*Method of Arrival: ☐ Air ☐ Train ☐ No Transfer Required	
*Departing City	
*Departing Country:	
*Arrival Flight Number:	
*Arrival Date:	*Arrival Time:
*Airport of Arrival:	
DEPARTURE FROM KAZAN	
*Method of Departure: ■ Air ☐ Train ☐ 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? ☐ Yes ■ No	
*Method of Departure: ☐ Air ☐ Train ☐ 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): Dieser Teil leer lassen	
*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/YYY):	License Expiry Date (DD/MM/YYY):
*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	