**Form B - Delegate / Coach**

**Delegation Name**

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First name

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Family name

**Address for insurance purpose (only permanent not mailing address)**

Street Number

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City Postal Code

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Telephone

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(include country code and/or area code)

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Gender (M/F/X) Date of Birth

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Nationality
 Place of Birth
(Code)

Passport ☐ ID card ☐ Number

**Please tick following:** HOD ☐ Head Coach ☐ Coach ☐

**Medical Information:** Is there a history of any of the following?

 YES NO
Heart Problems / High Blood Pressure ☐ ☐ Please list any allergies
Head injury / history of concussion ☐ ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Seizures ☐ ☐ Dietary restrictions
Asthma ☐ ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Are you a wheelchair user ☐ ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_