

VOLUNTEER, COACHES & UNIFIED PARTNER REGISTRATION FORM

Ages 18 and Older (valid for 3 years)

Special Olympics
Hawai'i



Special Olympics Hawai'i Delegation Name: _____

Registration Type (mark as many as pertains): Volunteer Coach Unified Partner

Are you a new or Re-Registering? New Re-Registering

VOLUNTEER / COACH / UNIFIED PARTNER INFORMATION

First Name:		Middle Name (required):	
Last Name:			
Date of Birth (mm/dd/yyyy):		<input type="checkbox"/> Female <input type="checkbox"/> Male	
Address:			
City:		State:	Postal Code:
Phone:		E-mail:	
Sports/Activities:			
Race/Ethnicity (Optional): Check all that apply			
<input type="checkbox"/> Asian		<input type="checkbox"/> Native Hawaiian	
<input type="checkbox"/> Black or African American		<input type="checkbox"/> or Other Pacific Islander (be specific) _____	
<input type="checkbox"/> White		<input type="checkbox"/> Hispanic or Latino	
Language(s) (Optional):			
<input type="checkbox"/> English <input type="checkbox"/> Other (please list): _____			
Employer Name (Optional):			
Name:		Position:	

EMERGENCY CONTACT INFORMATION

Name:	Relationship:	Phone:
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BACKGROUND INFORMATION

Do you use illegal drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been convicted of a criminal offense?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been charged with and/or convicted of neglect, abuse or assault?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your driver's license ever been suspended or revoked in any jurisdiction?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you answered "yes" to any of the questions, please provide details:	

INFORMATION NEEDED TO PERFORM BACKGROUND CHECK

Social Security Number:

Special Olympics will not keep your Social Security number submitted on this form. This part of the form will be detached and destroyed after your background check is completed.

**VOLUNTEER, COACHES & UNIFIED PARTNER
REGISTRATION FORM, page 2
Ages 18 and Older**



Name: _____

HEALTH INFORMATION **Health information is collected in case of emergency. Each participant is responsible for determining if the participant is physically able to participate.

Please mark if you have any of the following conditions and provide details:

- Special Dietary Needs:
- Allergies:
- Assistive or Implantable Devices:
- High Blood Pressure:
- Heart Condition:
- Asthma or Respiratory Condition:
- Mental Health Condition:
- Epilepsy or Seizure Disorder:
- Neurological Condition:
- Diabetes:
- Sickle Cell Anemia/Trait:
- Chronic Infection:
- Missing Organ (e.g., spleen, kidney):
- Other Health Conditions:

Please list any medications, vitamins, or dietary supplements below:

Medication Name	Dosage	Times per Day

Class A Volunteers, Coaches and Unified Partners who are 18 years of age and older are required to complete the online General Orientation and Protective Behaviors training. Access to those trainings can be found at <http://sohawaii.org>.

✂ -----
cut when background check is completed and information is inputted

OFFICE USE ONLY: Check when completed
BACKGROUND CHECKED AND INPUTTED: _____
UNIFIED PARTNER INPUTTED: _____

**VOLUNTEER, COACHES & UNIFIED PARTNER
RELEASE FORM, page 3
Ages 18 and Older**



I agree to the following:

1. **Ability to Participate.** I am physically able to take part in Special Olympics activities.
2. **Likeness Release.** I give permission to Special Olympics, Inc., Special Olympics games/local organizing committees, and Special Olympics accredited Programs (collectively “Special Olympics”) and Special Olympics partners and sponsors to use my likeness, photo, video, name, voice, words, and biographical information to promote Special Olympics, raise funds for Special Olympics, and acknowledge partners’ and sponsors’ support for Special Olympics.
3. **Risk of Concussion and Other Injury.** I know there is a risk of injury. I understand the risk of continuing to participate with or after a concussion or other injury. I may have to get medical care if I have a suspected concussion or other injury. I also may have to wait 7 days or more and get permission from a doctor before I start playing sports again.
4. **Emergency Care.** If I am unable, or my guardian is unavailable, to consent or make medical decisions in an emergency, I authorize Special Olympics to seek medical care on my behalf.
5. **Health Programs.** If I take part in a health program as a participant, I consent to health activities, screenings, and treatment. This should not replace regular health care. I can say no to treatment or anything else at any time.
6. **Personal Information.** I understand that Special Olympics will be collecting my personal information as part of my participation, including my name, image, address, telephone number, health information, and other personally identifying and health related information I provide to Special Olympics (“personal information”).
 - I agree and consent to Special Olympics:
 - using my personal information in order to: make sure I am eligible and can participate safely; run trainings and events; share competition results (including on the Web and in news media); provide health treatment if I participate in a health program; analyze data for the purposes of improving programming and identifying and responding to the needs of Special Olympics participants; perform computer operations, quality assurance, testing, and other related activities; and provide event-related services.
 - using my personal information for communications and marketing purposes, including direct digital marketing through email, text message, and social media.
 - sharing my personal information with (i) researchers, such as universities and public health agencies, that are studying intellectual disabilities and the impact of Special Olympics activities, (ii) medical professionals in an emergency, and (iii) government authorities for the purpose of assisting me with any visas required for international travel to Special Olympics events and for any other purpose necessary to protect public safety, respond to government requests, and report information as required by law.
 - I have the right to ask to see my personal information or to be informed about the personal information that is processed about me. I have the right to ask to correct and delete my personal information, and to restrict the processing of my personal information if it is inconsistent with this consent.
 - *Privacy Policy.* Personal information may be used and shared consistent with this form and as further explained in the Special Olympics privacy policy at www.SpecialOlympics.org/Privacy-Policy.aspx.
7. **Background Check Authorization.** I authorize Special Olympics to conduct a background check on me. This background check may be done through a third party. The background check may include an inquiry into my employment, education, driving, and/or criminal history. I understand that Special Olympics may rely on information provided or discovered to determine whether I may participate in Special Olympics activities. By signing below, I authorize investigators to conduct a background check as described in this form. I further authorize any third parties or agencies who may be in possession of the requested information, to disclose such information in connection with this background check.
8. **Waiver and Liability Release.** I understand the risks involved with participation in Special Olympics activities. I fully accept and assume all such risks and all responsibility for losses, costs, and damages I may incur as a result of my participation. I hereby release and agree not to sue any Special Olympics organization, its directors, agents, volunteers, and employees, and other participants (“Releasees”) related to any liabilities, claims, or losses on my account caused or alleged to be caused in whole or in part by the Releasees. I further agree that if, despite this release, I, or anyone on my behalf, makes a claim against any of the Releasees, I will indemnify and hold harmless each of the Releasees from any such liabilities, claims, or losses as the result of such claim. I agree that if any part of this form is held to be invalid, the other parts shall continue in full force and effect.

I have read and understand this form. If I have questions, I will ask. By signing, I agree to this form.		
Printed Name:	Delegation:	
Signature:	Date:	