

Participant Application - Summer Program

Adaptive Sports Foundation, PO Box 266, Windham, NY 12496
518-734-5070(p) 518-734-6740(fax) asfwindham@mhccable.com

Summer 2008

****PLEASE PRINT CLEARLY & FILL OUT ALL SECTIONS OF FORM****

SECTION 1:

Name: _____ Date of Birth: _____ Sex: Male or Female

Address: _____
(Street or PO Box) (City) (State) (Zip)

Phone Number: () _____ Emergency Number: () _____

Email Address: _____ County: _____

Group Name (if applicable): _____

New Student: ____ Returning Student: ____ Height: ____ Feet ____ Inches Weight: ____ lbs.

SECTION 2:

Disability: _____

PLEASE NOTE: If the individual has Down Syndrome, the ASF strongly recommends that the individual has been checked for AAI (Atlantoaxial Instability).

Please list all medications that the student is currently taking: _____

PLEASE NOTE: Participant must be able to administer their own medications or a parent or guardian must be present to administrative needed medications.

Please list past surgical procedures: _____

Please list recent/current illnesses, injuries, and or existing medical conditions: _____

Please list any special needs, diets, limitations or restrictions that the individual may have: _____

Please list any allergies (i.e.: medications, food, insect stings, etc.): _____

Please list any other concerns that the staff at the ASF should be aware of: _____

Primary Physician: _____ Phone: () _____



SECTION 3:

Activities and other sports involvement (Please check all that apply):

Please rate your skill level on a scale from 1 to 5 with each sport 1=beginner/never ever 5=expert

_____ Swimming _____ Skiing _____ Soccer _____ Sailing _____ Basketball

_____ Ice Skating _____ Water Skiing _____ Walking _____ Running _____ Gymnastics

_____ Tennis _____ Biking Other: _____

Physical Aids (Please check all that apply):

_____ Walker _____ Wheelchair _____ Crutches _____ Braces

Other (please specify): _____

Behavior & General Attitudes:

- (1) = Normal - No problems
- (2) = Mild Problem - Interferes occasionally
- (3) = Moderate Problem - Interferes frequently
- (4) = Severe Problem - Interferes constantly

ENTER above numbers to items below:

_____ Frustration tolerance _____ Hostility _____ Anxiety _____ Distractibility

_____ Impulsiveness _____ Following Directions _____ Problem Solving _____ Slowness of Speech

_____ Spatial Disorientation _____ Memory Loss _____ Temper _____ Confusion

_____ Ability to Self Correct _____ Slowness of Cognitive

Secondary Problems:

Circulatory in Limbs _____ Diabetes _____

Cardiovascular _____ Visual Loss _____

Seizures (circle one) YES NO If yes, controlled with medications (circle one) YES NO

Type of Seizure _____ Date of last seizure _____

Bladder Management: Self - YES NO Catheter - YES NO Leg Bag - YES NO Other: _____

Endurance Level (circle one): NORMAL DECREASE W/ACTIVITY

Hearing Loss: _____ Sensory Loss: _____ Other: _____

Motor Status:

Please list any problems with MUSCLE TONE, RANGE OF MOTION or STRENGTH below and also note any SPASTICITY or PARALYSIS and area(s) affected. _____

Goals & General Information:

Please list your goals for attending the Adaptive Sports Foundation Summer Sport Program: _____

**Adaptive Sports Foundation
Corporate Sponsors & Supporters**













PLEASE CONTINUE TO PAGE 3



SECTION 4: If the participant is 17 years old or younger, the following form **MUST** be completed. If the participant is 18 years or older the completion of the following form is optional.

ATTENTION:

If the participant is 17 years old or younger a note from their primary physician stating that the individual is medically capable of participating in camp activities is required.

Please attach note to the application.

GENERAL MEDICAL HISTORY

Please list any diet restrictions or food allergies: _____

Please list any other medical problems (such as allergies, allergies to certain medications, asthma, hay fever, etc.): _____

Is the participant incontinent? Yes ___ No ___ Urine ___ Stool ___ Frequency _____

Does the participant have a history of seizures? Yes ___ No ___

If yes, please describe the type of seizure. _____

When was the last seizure? _____ How frequent are the seizures? _____

If female, has the participant begun her menstrual period? _____ Any problems? _____

Special needs/care requirements (fluid needs, vision/hearing loss) Is catheterization needed? If so, how frequent? _____

Level of assistance required for personal hygiene care:

Independent _____ Minimal _____ Moderate _____ 1:1 _____

IMMUNIZATION RECORD

(for 17 years old or younger participants)

NOTE: If the individual is not immunized because of religious beliefs; a written and signed statement from the parent or guardian, stated that the person objects to their child's immunization must be included with this application. Also, if the individual is not immunized due to a medical exemption - i.e.: severe immunosuppression, etc. or because there is a documented history of disease - i.e.: measles, mumps, etc. or serologic immunity - i.e.: measles, rubella, hepatitis B, signed by a physician, this certificate must be included with the application.

Indicate one: Immunity to chicken pox is required unless medically contraindicated.

___ (1) This child is IMMUNE to Varicella (Chicken Pox) by reason of ___ Clinical disease

___ Positive titer ___ or Varivax vaccine [date(s) _____] OR

___ (2) This child is NOT IMMUNE to Varicella and the vaccine is contraindicated for him/her.

List reason contraindicated _____

Participants under 17 years of age **MUST** have had at least 4 DPT's or DT's and the most recent must be less than 10 years ago:

Did the participant have DPT ___ or DT ___ (that is no pertussis)

Has he/she has at least 4 doses total? Yes ___ No ___ Date of last DPT ___ DT ___ or dT ___

Participants under 17 years of age **MUST** have 2 MMR's or 1 MMR & a 2nd measles vaccine.

Date of 1st ___ Date of 2nd ___

Participants under 17 years of age **MUST** have completed polio vaccines - 3 or 4 doses of TOPV ___ or IPV ___

Is series complete? _____

PLEASE CONTINUE

We strongly recommend the following, but the following vaccines are not mandatory for participants. **PAGE 5**

HIB (Hemophilus) is the participant fully immunized? Yes ___ No ___

Pneumococcal vaccine - Date: _____

Hep B vaccine - Date: _____



SECTION 6: This MUST be signed before ANY participant can participate in any ASF Program.

**DISABLED SPORTS USA'S CHAPTER/AFFILIATES INSURANCE WAIVER
AND RELEASE OF LIABILITY**

Please read:

In consideration of being allowed to participate in any way in the Windham Mountain. and the Adaptive Sports Foundation (chapter affiliate name) programs, related events and activities, I and/or the minor participant, for myself, and on behalf of my heirs, assigns, personal representatives and next of kin, the undersigned:

1. Agree that prior to participating, I will inspect, or if a parent and/or legal guardian, I will instruct the minor participant to inspect, the facilities and equipment to be used, and if I believe to the best of my ability that anything is unsafe, I and/or the minor participant will immediately advise the Adaptive Sports Foundation of such condition (s) and refuse to participate. (chapter/affiliate name)
2. Acknowledge and fully understand that I and/or the minor participant, will be engaging in activities that involve risk of serious injury, including permanent disability and death, and severe social and economic losses which might result only from my own actions, inactions or negligence of others, the rules of play, or the condition of the premises or any equipment use. Further, that there may be other risks not known to me or not reasonably foreseeable at this time.
3. Assume all the foregoing risks and accept personal responsibility for the damages to me following such injury, permanent disability or death.
4. Release, waive, discharge and covenant not to sue Windham Mountain and the Adaptive Sports Foundation, Disabled Sports USA, it's (chapter/affiliate name) affiliated clubs, their representative administrators, directors, agents, coaches and other employees of the organization, other participants, sponsoring agencies, sponsors, advertisers, their heirs, and if applicable, owners and leasers of premises used to conduct the event, all of which are hereinafter referred to as "releasees", from demands, losses or damages on account of injury including death or damage to property, caused or alleged to be caused in whole or in part by the negligence of the releasee or otherwise.

I/WE HAVE READ THE ABOVE WAIVER AND RELEASE, UNDERSTAND THAT I/WE HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, HAVE NOT CHANGED IT ORALLY, AND SIGN IT VOLUNTARILY.

Participant's Name	Signature	Date
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FOR PARTICIPANTS OF MINOR AGE

This is to certify that I, as parents/guardian with legal responsibility for this participant, do consent to agree to his/her release as provided above of the Releasees, and, for myself, my heirs, assigns and next of kin, I release and agree to indemnify and hold harmless the Releasees from any and all liabilities incident to my minor child's involvement or participation in these programs as provided, **EVEN IF ARISING FROM THEIR NEGLIGENCE.**

1st Parents Signature and Emergency Number	Name and Date
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2 nd Parents Signature and Emergency Number	Name and Date
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SECTION 5:

Recognizing that sports can be hazardous, I hereby release ASF, Windham Mountain, and/or the host area and agents and employees from liability from any and all injuries of whatever nature rising during or in connection with the conduction of the lesson (program) for which this application is made.

I agree that all disputes and/or lawsuits under this contract and/or from my use of the facilities at Windham Mt. and/or the host area shall be litigated exclusively in the Supreme Court of the State of New York, County of Greene, or in the United States District Court for the Northern District of New York.

I HAVE or HAVE NOT (circle one) contacted my physician or physical therapist regarding my participation in the sports offered and programs. I accept any and all responsibility for anything that might occur to me while participating in the sports & activities being offered by the Adaptive Sports Foundation.

SIGNATURE: _____ **DATE:** _____

I hereby give my permission to have photographs taken and used for the purpose of providing visual publicity for the ASF.

SIGNATURE: _____ **DATE:** _____



Adaptive Sports Foundation
Summer Program

2007 Reservation Form

Adaptive Sports Foundation
POB 266, 100 Silverman Way
Windham, NY 12496
518-734-5070 Phone
518-734-6740 Fax

Name of Participant: _____

Phone (Day) _____ Phone (Ev) _____ Phone (Cell) _____

Local Phone (if applicable) _____ Email Address (please print clearly): _____

Program communications and cancellations are most easily accomplished via e-mail.
Is this a good way to communicate with you? ____ Yes ____ No ____ Please call

Please circle the dates & activities you would like to participate in.
NOTE: Phone reservations are also accepted.

**Specific pricing and program description are included in the
Summer Program 2007 brochure included with this mailing**

JULY 2007		
Date	Program	Deadline
7/14/07	Waterfront Activity Day Camp <i>Open to cognitively and physically impaired children and adults.</i>	7/2/07
7/15/07	Waterfront Activity Day Camp <i>Open to cognitively and physically impaired children and adults.</i>	7/2/07
7/21/07	Waterfront Activity Day Camp <i>Open to visually impaired children and adults.</i>	7/9/07
7/22/07	Waterfront Activity Day Camp <i>Open to visually impaired children and adults.</i>	7/9/07

AUGUST 2007		
Date	Program	Deadline
8/17/07- 8/19/07	EAGA First Swing Golf Camp <i>Open to physically impaired children and adults.</i>	8/13/07
8/25/07	Waterfront Activity Day Camp <i>Open to cognitively and physically impaired children and adults.</i>	8/13/07
8/26/07	Waterfront Activity Day Camp <i>Open to cognitively and physically impaired children and adults.</i>	8/13/07

Students under the age of 18 at the time of the program must be accompanied by a parent or companion

SESSION TIMES

Session times and locations will be confirmed with the participant
via email or phone call 5 days prior to session date.

Please see brochure or call the ASF for program rates – we will be happy to assist you!

TOTAL AMOUNT TO BE CHARGED or ENCLOSED: \$_____ Checks Payable to the Adaptive Sports Foundation

Credit Card # _____ Exp. Date: _____

Signature: _____ ****MASTERCARD, VISA & AMEX ONLY****

SPECIAL GROUPS

Group sessions must be scheduled through the office. Please call to determine activity schedule, dates, and cost.

Please take a minute to fill out participant information included on the reverse of this form.



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2007 Participant Form

Adaptive Sports Foundation
POB 266, 100 Silverman Way
Windham, NY 12496
518-734-5070 Phone
518-734-6740 Fax

Participant Name: _____ Today's Date: _____

Please complete the following questions regarding your participation in the following ASF summer programs – this information will help us immensely in preparing our program and staff to best meet your needs

SWIMMING ABILITY

(Required for all waterfront activities; participants in the paddling program must be comfortable in the water)

- The student is:
1. _____ able to swim on his/her own and does not require direct supervision (in addition to the lifeguard)
 2. _____ able to stay afloat and swim short distances, but requires direct supervision (in addition to the lifeguard)
 3. _____ learning how to swim and/or the disability requires one-on-one supervision
 4. _____ must wear a lifejacket at all times and requires one-on-one supervision.

Is the student fearful of the water? _____ Yes _____ No

CYCLING

(for groups, no individual reservations please.)

- Does the student:
1. _____ ride a bike independently,
 2. _____ ride a bike independently but require direct supervision,
 3. _____ wish to learn how to ride a bicycle?

The student: _____ owns his/her own cycle _____ will be using ASF equipment

- The student will use:
1. _____ a handcycle
 2. _____ a recumbent bike
 3. _____ a two-wheeler with helper wheels
 4. _____ a two-wheeler