



Adaptive Sports Foundation

PO Box 266, 100 Silverman Way
Windham, New York 12496
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asfwindham@mhcable.com (email)

2009-2010

Participant is New Returning Male Female Skier Snowboarder

Participant Name: _____
Last First Middle

Address: _____
Street City State Zip

County (ie. Westchester): _____ e-mail: _____

Cell phone () _____ Lodging phone () _____

Emergency Contact _____ Cell phone () _____
Last First

Home phone () _____ Parent / Guardian _____

Group name (if applicable): _____

Rentals Required Y/N _____ Shoe Size _____ Waist (inches)* _____ Hip (inches)* _____

Date of birth: _____ Age: _____ Height: _____ Weight: _____

**required field for sit skiers - Due to manufacture requirements there is a 200 lb. limit on sit skis*

Primary Disability list:

- | | | |
|--|---|---|
| <input type="checkbox"/> Autism Spectrum | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Hearing impaired |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Spinal Cord Injury |
| <input type="checkbox"/> Learning disability | <input type="checkbox"/> Traumatic Brain Injury | <input type="checkbox"/> Visual impairment |
| <input type="checkbox"/> Downs syndrome | <input type="checkbox"/> Amputee | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Developmentally delayed | | |
| <input type="checkbox"/> OTHER (please use the blank form) _____ | | |

Mobility needs (i.e.: power or manual wheelchair, walker, crutches, cane) : _____

Level of stamina : fatigues easily age appropriate strength & energy level
 varies (depends on medications & disability process)

Seizure history: NO YES

Type of seizures: petit mal grand mal focal

Date of last seizure: _____

Participant's name: _____

Activities of daily living (*mobility, hygiene, feeding, etc,etc,etc*) **ASF does not administer medications or toilet participants*

Independent (*freely ambulates or independently uses wheelchair, crutches, walker, cane; transfers to and from vehicles and navigates crowds on own, manages own medications, meals, bowel and bladder needs including catheterizations*)

Assisted (*requires assistance with transfers to and from vehicles or toileting; continues to manage own meals, medications and crowds*)

Dependent (*requires someone else to perform all the activities of daily living for them*)

Medications **Not applicable** **if necessary please use the back*

Medication	Dosage & schedule	Reason for taking

Food or Drug Allergies **No known allergies** **if necessary please use the back*

Allergy	Reaction

Please list medical procedures and implanted devices include location and approximate date of the procedure (*i.e. fracture repairs with rods & pins, shunts, feeding tubes, insulin pumps, grafts*): **Not applicable**

If you have participated in another adaptive program, please provide the name of the program and any equipment you used: **Not applicable**

Name _____

DS/USA INSURANCE WAIVER & RELEASE OF LIABILITY FORM and MEDIA RELEASE FORM

Please note: there are two places on this sheet that require a signature

DS/USA INSURANCE WAIVER & RELEASE OF LIABILITY FORM

In consideration of being allowed to participate in any way in DISABLED SPORTS USA, Adaptive Sports Foundation and/or Windham Mountain's 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 DISABLED SPORTS USA of such condition(s) and refuse to participate.
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 used. 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 following such injury, permanent disability or death.
4. Release, waive, discharge and covenant not to sue DISABLED SPORTS USA, Adaptive Sports Foundation and/or Windham Mountain, its 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.

X _____
Participant's Name (PLEASE PRINT CLEARLY) Signature
Date

FOR PARTICIPANTS UNDER THE AGE OF 18

This is to certify that I, as parent/guardian with legal responsibility for this participant, do consent and 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 above, EVEN IF ARISING FROM THEIR NEGLIGENCE.

X _____
Parent's Signature & Emergency Phone Name & Date

MEDIA RELEASE FORM

MEDIA/PHOTO WAIVER: I hereby authorize and give my full consent to Disabled Sports USA to copyright and/or publish any and all photographs, videotapes and/or film in which I appear while attending this DS/USA event. I further agree that DS/USA, Adaptive Sports Foundation and/or Windham Mountain may transfer, use or cause to be used, these photographs, videotapes, or films for any exhibitions, public displays, publications, commercials, art and advertising purposes, and television programs without limitations or reservations.

X _____
Signature of Participant/Guardian Date



Participant's name: _____

The following categories pertain to specific disabilities. Please complete the section(s) that most describe the participant's disability(ies) and/or secondary conditions that may exist.
PLEASE RETURN ONLY THE COMPLETED PAGES

Autism Spectrum Attention Deficit Disorder

Primary disability

Secondary condition

1. Please identify the type

Autism (Mild Moderate Severe Aspergers PDD OTHER) ADD ADHD

2. Age at time of diagnosis _____

3. If Other Autism, please identify the diagnosis _____

4. Please describe behaviors the ASF staff should be aware of , include methods to soothe and reward participant: **if necessary please use the back*

5. Level of supervision required: 1:1 all day group supervision only when upset none

6. Please check all the characteristics that apply

ADD / ADHD

- Difficulty following directions or finishing tasks Difficulty staying seated or in line
- Excessive talking / interrupts frequently Ignores details
- Appears forgetful

AUTISM

- Speaks in single words Speaks in 2 – 3 word phrases
- Speaks in complete sentences Uses gestures / points
- Uses pictures / cue cards Uses communication board
- Uses personal sounds Writes / draws wants or needs
- Overactive Short attention span
- Low activity level – needs motivation Easily distracted by sensory stimuli

Sensory triggers (i.e. sounds, sights, smells) **if necessary please use the back*

Of those items checked, please provide information you feel would be helpful to ASF staff in providing a successful experience: **if necessary please use the back*



Participant's name: _____

The following categories pertain to specific disabilities. Please complete the section(s) that most describe the participant's disability(ies) and/or secondary conditions that may exist.
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Learning Disability / Traumatic Brain Injury

Primary disability

Secondary condition

1. What caused the disability _____

2. Date of diagnosis _____

3. Please check all the characteristics that apply

- | | | |
|--|--|--|
| <input type="checkbox"/> Hemiplegia | <input type="checkbox"/> Non-verbal | <input type="checkbox"/> Poor judgment |
| <input type="checkbox"/> Spasticity | <input type="checkbox"/> Uncooperative | <input type="checkbox"/> Difficulty with abstract thoughts |
| <input type="checkbox"/> Joint Rigidity | <input type="checkbox"/> Depression | <input type="checkbox"/> Difficulty with decision making |
| <input type="checkbox"/> Altered gait | <input type="checkbox"/> Angers easily | <input type="checkbox"/> Unaware of the limitations |
| <input type="checkbox"/> Poor balance | <input type="checkbox"/> Extreme emotional responses | <input type="checkbox"/> Decreased function level |
| <input type="checkbox"/> Difficulty sequencing tasks | <input type="checkbox"/> Poor coordination | <input type="checkbox"/> Does not consider consequences |
| <input type="checkbox"/> Hyperactivity | | |

Of those items checked, please provide information you feel would be helpful to ASF staff in providing a successful experience: **if necessary please use the back*

Down Syndrome / **Developmental Delay**

Primary disability

Secondary condition

Please check all the characteristics that apply

- | | | |
|---|---|---|
| <input type="checkbox"/> Heart defect | <input type="checkbox"/> Poor muscle tone | <input type="checkbox"/> Non-verbal |
| <input type="checkbox"/> Difficulties with speech | <input type="checkbox"/> Difficulties with vision | <input type="checkbox"/> Difficulties with hearing |
| <input type="checkbox"/> IQ 80 or below | <input type="checkbox"/> Poor hand eye coordination | <input type="checkbox"/> Expressive language delays |
| <input type="checkbox"/> Social delays | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Joint limitations | <input type="checkbox"/> Hyperflexibility | <input type="checkbox"/> Atlantoaxial instability* |

***ASF strongly encourages participants with Down Syndrome be evaluated for Atlantoaxial instability**

Of those items checked, please provide information you feel would be helpful to ASF staff in providing a successful experience: **if necessary please use the back*



Participant's name: _____

The following categories pertain to specific disabilities. Please complete the section(s) that most describe the participant's disability(ies) and/ or secondary conditions that may exist.
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Spinal Cord Injury **Spina Bifida** **Cerebral Palsy** **MS** **MD**

Primary disability

Secondary condition

1. Please identify the type

Spinal Cord Injury location (*i.e.* T-4, C-6) _____

Complete Incomplete Paraplegia Quadriplegia

Spina Bifida Meningocele Myelomeningocele

Cerebral Palsy Spastic Athetoid Ataxic Mixed

2. If SCI was checked, what was the cause? _____

3. Date of diagnosis _____

4. Please check all the characteristics that apply

- Hydrocephalus
- Autonomic dysreflexia
- Involuntary movements
- Bowel / bladder control
- Sequencing difficulty

- Latex allergies
- Muscle spasms
- Gait / mobility disturbances
- Cognitive delays
- Speech difficulty

- Seizures / Epilepsy
- Contractures
- Abnormal sensations
- Learning disabilities

5. Methods used to prevent skin breakdown

Of those items checked, please provide information you feel would be helpful to ASF staff in providing a successful experience: **if necessary please use the back*



Participant's name: _____

The following categories pertain to specific disabilities. Please complete the section(s) that most describe the participant's disability(ies) and/ or secondary conditions that may exist.
PLEASE RETURN ONLY THE COMPLETED PAGES

Amputee

Primary disability Secondary condition

1. Please identify the type of amputation

- Right Left Bilateral
- Above Knee Below Knee
- Above elbow Below elbow
- Complete upper limb Complete lower limb

2. Date of amputation: _____

3. Cause of amputation:

Please check all that since the amputation

- Limb pain Weight gain Depression
- Skin breakdown Decreased physical activity

4. How do you protect your amputated limb from cold and injury:

5. How do you protect your amputated limb from pressure ulcers:

6. Do you intend to wear your prosthesis while taking part in the program ? YES NO

Of those items checked, please provide information you feel would be helpful to ASF staff in providing a successful experience: **if necessary please use the back*



Participant's name: _____

The following categories pertain to specific disabilities. Please complete the section(s) that most describe the participant's disability(ies) and/ or secondary conditions that may exist.
PLEASE RETURN ONLY THE COMPLETED PAGES

Visual Impairment

Primary disability Secondary condition

1. Visual impairment Partially sighted / Legally Blind Totally blind

2. Date of diagnosis _____

3. Cause for the visual impairment

- Cataracts Glaucoma Trauma
- Retinopathy Macular Degeneration Diabetes
- Optic Atrophy Retinitis Pigmentosa
- Other _____

4. To aid in mobility, does the visually impaired student use; cane guide guide dog
Of those items checked, please provide information you feel would be helpful to ASF staff in providing a successful experience: **if necessary please use the back*

Hearing Impairment

Primary disability Secondary condition

1. Hearing impairment Partial hearing loss Total hearing loss

2. Date of diagnosis _____

3. Please explain the reason for the hearing loss:

4. How does the participant communicate with others:

Of those items checked, please provide information you feel would be helpful to ASF staff in providing a successful experience: **if necessary please use the back*



Participant's name: _____

The following categories pertain to specific disabilities. Please complete the section(s) that most describe the participant's disability(ies) and/ or secondary conditions that may exist.
PLEASE RETURN ONLY THE COMPLETED PAGES

OTHER DISABILITY

Primary disability Secondary condition

1. Name of the disability: _____

2. Age at time of diagnosis: _____

3. Cause of disability (if known):

4. Impairment: Physical Cognitive Developmental **check all that apply*

5. Please check all the characteristics that apply

- | | |
|---|--|
| <input type="checkbox"/> short attention span | <input type="checkbox"/> inappropriate behavior |
| <input type="checkbox"/> difficulty sequencing tasks | <input type="checkbox"/> difficulty with abstract thinking |
| <input type="checkbox"/> poor judgment | <input type="checkbox"/> does not consider consequences |
| <input type="checkbox"/> depression | <input type="checkbox"/> difficulty following directions |
| <input type="checkbox"/> unable to detect heat / cold | <input type="checkbox"/> contractures |
| <input type="checkbox"/> unsteady gait, managed with use of cane, walker, etc, etc. | |

Provide additional information regarding the disability or secondary condition as it pertains to snow sports activities **if necessary please use the back*

Of those items checked, please provide information you feel would be helpful to ASF staff in providing a successful experience: **if necessary please use the back*

