Adaptive Sports Foundation
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Windham, New York 12496
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asfwindham@mhcable.com (email)

2011-2012

PARTICIPANT FORM FOR NEW STUDENTS

Participant Name: ____
Last *First* *Middle*

Address:____
Street *City* *State* *Zip*

County *(ie. Westchester)*: ______________________ Parent/Guardian:______________________

Home Ph.( )______________ Cell Ph.( ) ______________Local/Lodging Ph.( ) ______________

Email:______________________________

Emergency Contact: ______________________________ Cell phone ( ) ______________
Last *First*

Group name *(if applicable)*: ____

Participant will be: ☐Skiing ☐Snowboarding Rentals Required: ☐Yes ☐No Shoe Size (if renting) ________

Gender:☐ Male ☐Female Date of birth ____________ Age: ______Height: ______ Weight: ________

Do you anticipate that the student will sit ski? ☐Yes ☐No If yes: ☐ monoski ☐ bi-ski ☐don't know

Due to manufacture requirements there is a 200 lb. limit on sit skis

The student's disability is: ☐ Physical ☐ Cognitive ☐Both
Please check the primary disability:

☐ ADD/ADHD	☐ Amputee	☐ Autism Spectrum
☐ Cerebral Palsy	☐ Developmentally delayed	☐ Downs syndrome
☐ Hearing impaired	☐ Learning disability	☐ Muscular Dystrophy
☐ Multiple Sclerosis	☐ Post Traumatic Stress Disorder	☐ Spina Bifida
☐ Spinal Cord Injury	☐ Stroke	☐ Traumatic Brain Injury
☐ Visual impairment		

☐ OTHER (please describe) ____

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:** ______________________

Behavior & General Attitudes:
Enter the numbers to items below: (1)=Normal (2)=Mild problem (3)=Moderate problem (4)=Severe problem

____Frustration tolerance ___Confusion ___Anxiety ___Distractibility ___Temper

___Impulsiveness ___Following directions ___Memory loss ___Hostility ___Spatial disorientation

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**

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

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Sports experience: Please circle all activities that the applicant has previously participated in.

Skiing (beginner, novice, intermediate) Snowboarding (beginner, novice, intermediate)

Skating Swimming Tennis Waterskiing Biking Skateboarding

Other: ____

DISABLED SPORTS USA INSURANCE WAIVER & RELEASE OF LIABILITY and MEDIA RELEASE FORM

DISABLED SPORTS USA INSURANCE WAIVER & RELEASE OF LIABILITY FORM

In consideration of being allowed to participate in any way in Disabled Sports USA and Adaptive Sports Foundation 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 and Adaptive Sports Foundation 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 and Adaptive Sports Foundation, its affiliated clubs, their representative administrators, directors, agents, coaches, other employees, and volunteers 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 Signature **Participant's Name (PLEASE PRINT CLEARLY)** **Date**

Date of Birth ____________ **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/Legal Guardian Signature **Parent/Legal Guardian Name** **Relationship** **Emergency Phone** **Date**

MEDIA RELEASE FORM

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

X________________________ ________________________ ____________

Participant's Signature **Participant's Name (PLEASE PRINT CLEARLY)** **Date**

FOR PARTICIPANTS UNDER THE AGE OF 18

X________________ ________________ ____________ ____________ ________

Parent/Legal Guardian Signature **Parent/Legal Guardian Name** **Relationship** **Emergency Phone** **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 Austim, 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*

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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*

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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*

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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

☐ Hemiplegia	☐ Non-verbal	☐ Poor judgment
☐ Spasticity	☐ Uncooperative	☐ Difficulty with abstract thoughts
☐ Joint Rigidity	☐ Depression	☐ Difficulty with decision making
☐ Altered gait	☐ Angers easily	☐ Unaware of the limitations
☐ Poor balance	☐ Extreme emotional responses	☐ Decreased function level
☐ Difficulty sequencing tasks	☐ Poor coordination	☐ Does not consider consequences
☐ 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*

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☐ Down Syndrome / ☐ Developmental Delay

☐ Primary disability ☐ Secondary condition

Please check all the characteristics that apply

☐ Heart defect	☐ Poor muscle tone	☐ Non-verbal
☐ Difficulties with speech	☐ Difficulties with vision	☐ Difficulties with hearing
☐ IQ 80 or below	☐ Poor hand eye coordination	☐ Expressive language delays
☐ Social delays	☐ Anxiety	☐ Hyperactivity
☐ Joint limitations	☐ Hyperflexibility	☐ 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*

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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

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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*

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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:

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

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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*

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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
☐ Retinopathy
☐ Optic Atrophy
☐ Other ____
☐ Glaucoma
☐ Macular Degeneration
☐ Retinitis Pigmentosa
☐ Trauma
☐ Diabetes

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*

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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:
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4. How does the participant communicate with others:
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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*

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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

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

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