



**Adaptive Sports Foundation**  
PO Box 266, 100 Silverman Way  
Windham, New York 12496  
518-734-5070 (phone)  
518-734-6740 (fax)  
sluppino@mhccable.com (email)  
www.adaptivesportsfoundation.org

## Wounded Warrior Learn to Ski & Ride Event January 19-22, 2012

### General Info

**Registration Instructions:** Please return completed forms to the Adaptive Sports Foundation via fax, email, or mail. You are not registered until we receive your forms AND you receive a confirmation email from the ASF.

Name: (name that matches your ID) \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

County: \_\_\_\_\_ Daytime Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Email: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Jacket size: \_\_\_\_\_ Have you attended this event before? Yes or No (If Yes) When did you attend? \_\_\_\_\_

### Guest Info

Name of Guest traveling with you (name that matches your ID): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ My Guest would like to: Ski or Snowboard

Lessons: Yes or No Experience: Skiing \_\_\_\_\_ Snowboarding \_\_\_\_\_ (1=never participated; 2=novice; 3=intermediate; 4=expert)

Will they need rental equipment? Yes or No Shoe Size: \_\_\_\_\_ (M / W) Height: \_\_\_\_\_ ft \_\_\_\_\_ in Weight: \_\_\_\_\_ lbs.

\*Special accommodations may be made for Warriors with families. Please contact the Adaptive Sports Foundation to learn more.

### Travel Info

Where are you traveling from? \_\_\_\_\_

IF you are flying, what airport would you like to fly out of? \_\_\_\_\_

Please indicate any special accommodations we should know about when making your plane reservations (i.e.: service dog, early boarding, wheelchair, etc.) \_\_\_\_\_

IF you would like to take AMTRAK, what station would you like to originate from? \_\_\_\_\_

IF you are driving, what is the address you would be traveling from so we can send you directions? \_\_\_\_\_

Will you be traveling with a service dog? \_\_\_\_\_ Will you need lodging on the first floor for accessibility? \_\_\_\_\_

## Sport Info

I would like to (please circle one)		Ski	Snowboard
Shoe size: _____	Height: _____ feet _____ inches	Weight: _____ lbs.	
Sports experience: Please rate your ability at the following sports: 1=never participated; 2=novice; 3=intermediate; 4=expert			
<b>Skiing</b> _____	<b>Snowboarding</b> _____	Biking _____	Hiking _____ Kayaking _____ Golf _____ Swimming _____
Other: _____			
<b>GENERAL FITNESS: (check one)</b>			
1. _____ I don't participate in sports or working out at the gym		2. _____ I haven't been doing many sports or working out lately	
3. _____ I participate in sports or work out once or twice a week		4. _____ I participate in sports or work out several times a week	

## Disability Info

Disability: _____			
Secondary conditions: _____			
Please list all medications you are currently taking: _____			
Mental ability (check one) _____ Normal functioning _____ Mildly challenged _____ Moderately challenged _____ Severely Challenged			
Hearing (check one)	_____ Normal	_____ Mild/Moderate Loss	_____ Severe/ Total
C. Speech (check one)	_____ Normal	_____ Mild to moderately affected.	_____ Non-verbal
Vision (check one)	_____ Normal	_____ Mild to moderately impaired	_____ Completely blind
E. Mobility (check all that apply)	_____ Ambulatory	_____ Non Ambulatory	_____ Walks with crutches _____ Uses a wheelchair
Uses wheelchair exclusively	_____ Yes _____ No	_____ Yes-Electric	_____ Yes-Manual
G. Seizures	_____ Yes _____ No	If yes, what was the date of your last seizure? _____	
		Type of seizure: _____	
H. Behavior & General Attitudes:			
<i>Enter the numbers to items below: (1)=Normal (2)=Mild problem (3)=Moderate problem (4)=Severe problem</i>			
_____ Frustration tolerance	_____ Hostility	_____ Confusion	_____ Anxiety _____ Distractibility _____ Impulsiveness
_____ Following directions	_____ Memory loss	_____ Temper	_____ Spatial disorientation
I. Bladder Management	_____ Self _____ No	If no, Catheter or Leg bag	

## Other Info

Please list any other conditions or issues the ASF should be aware of. _____
_____
_____
_____
_____



### Alumni Information Form

Name (First, Last):		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth (MM/DD/YYYY):	
Mailing Address (Permanent Address):			City:		State: Zip:
Home Phone:		Alternate Phone:		Mobile:	
Email Address:			Email 2:		
Media Willingness: <input type="checkbox"/> Yes <input type="checkbox"/> No			Level of Education:		
Occupation/Title:			Marital Status:		
Alternate/Emergency Contact:		Relationship:		Phone:	
Branch of Service: <input type="checkbox"/> Air Force <input type="checkbox"/> Army <input type="checkbox"/> Marines <input type="checkbox"/> Navy <input type="checkbox"/> National Guard <input type="checkbox"/> Other:					
Service Start Date:			Service Status:		
Type of Discharge:			Rank:		
Anticipated Service End Date:			Has DD214: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date of Injury:			Location of Injury (Iraq, Afghanistan, Stateside, Other):		
Injury / Disability:					
Are you receiving inpatient care? <input type="checkbox"/> Yes <input type="checkbox"/> No			Location of Hospitalization:		
<input type="checkbox"/> Amputee <input type="checkbox"/> Blind <input type="checkbox"/> PTSD <input type="checkbox"/> SCI <input type="checkbox"/> SFW/GSW <input type="checkbox"/> TBI <input type="checkbox"/> Other _____					
Injury Description:					
Receiving VA Compensation?			Have You Applied For VA Benefits: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you have a pending VA Claim: <input type="checkbox"/> Yes <input type="checkbox"/> No			Do you have a VA claim on Appeal? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Claim Manager (WWP, NVLSP, VFW, Private Attorney, Other)?			VA Rating?		
TSGLI?			SSA Benefits?		
Has applied for VRB? If so, receiving VRB?			Other information:		