

Name: (Participant) _____ Daytime Phone: _____
 Email: _____ Cell Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____
 County: _____ Occupation: _____ Military Rank & Branch: _____
 Emergency Contact: _____ Relation: _____ Cell Phone: _____
 Emergency Contact: _____ Relation: _____ Cell Phone: _____

If Participant is a Minor or Dependent Adult:

Guardian: _____ **Relation:** _____ **Occupation:** _____
 Address: _____ City: _____ State: _____ Zip: _____
 Email: _____ Primary Phone: _____ (H W C)

PARTICIPANT DISABILITY: _____ How long? _____

Date of Birth: _____ Height: _____ Weight: _____ Male/Female: _____ Ethnicity: _____

For participants with Down Syndrome: We require an examination by a physician for ***Atlantoaxial Instability*** before participating. Physician Results/Findings: _____

Please give explanations in space provided below.

“Does Participant...”

1. Have seizures? _____ Type? _____ Frequency? _____ Date of last seizure? _____
 Seizure management (e.g. Meds, etc.): _____
2. Have allergies (e.g. latex, bees, foods, drugs)? _____
3. Take medications we should be aware of? _____
4. Need precautions taken for any injuries or surgeries in the past 6 months? _____
5. Have other hidden medical conditions? _____
6. Have sensitivity to cold, heat or sun? _____ Fatigue easily? _____
7. Have a respiratory condition? _____ Have a cardiovascular condition? _____
8. Use manual wheelchair? _____ What % of time? _____ Power wheelchair? _____ What % of time? _____
9. Need assistance operating wheelchair? _____ Transferring to or from wheelchair? _____
10. Walk? _____ What % of time? _____ With what kind of aid? _____
11. Wear any braces? _____ Type of brace: _____
12. Have rods stabilizing any part of spine? _____ How long: _____
13. Have any pressure sores/significant bruises? _____
14. Describe communication abilities. _____
15. Describe vision and hearing abilities. _____
16. Describe behavioral tendencies. _____
17. Describe cognitive level. _____
18. Describe arm strength _____ grip strength _____ feeling _____ range of motion _____
19. Describe leg strength _____ balance _____ feeling _____ range of motion _____
20. How long can you be independent from medications, oxygen, etc. that you cannot have on your person? _____

How did you hear about us? _____

Please read and initial that you understand these program requirements:

ALL SPORTS

Health and Safety:

- ◆ If you think participating in Achieve Tahoe programs below may cause you pain or injury, please consult your doctor and provide us with a doctor's written release prior to participating. **Initial** _____

Personal Care:

- ◆ If help is needed with bladder or bowel routine, feeding tube, or administering prescription medications attendant or family member will be present to assist. **Initial** _____

SNOW SPORTS

- ◆ Sit-down skiers weight limit is 185 lbs. Exceptions will be considered for skiers who are fully independent transferring from wheelchair to ski and loading and unloading chairlift. **Initial** _____
- ◆ While strapped in a sit-down ski you will unload the chairlift, with assistance, by dropping down as much as 2 feet onto the unloading ramp. In this unloading process, your hips and back must be able to sustain this jarring. **Initial** _____

SUMMER SPORTS

Water skiing:

- ◆ Wheelchair users seat cushion width may not be greater than 18". **Initial** _____
- ◆ You are able to turn face-up from a face-down floating position in the water, while wearing a life vest. **Initial** _____
- ◆ Skiers will be towed behind or alongside a motorboat at speeds up to 25 mph. Should you fall, your body must be able to sustain the impact of hitting the water at these speeds. **Initial** _____
- ◆ If help is needed with bladder or bowel routine, feeding tube, or administering prescription medications attendant or family member will be present to assist. **Initial** _____

4-wheel drive trips:

- ◆ Weight limit is 185 lbs. for wheelchair users. Exceptions will be considered if you are fully independent and strong enough to transfer down and up about 12". **Initial** _____
- ◆ You will experience a bouncing motion from the vehicle driving over rough terrain. **Initial** _____
- ◆ Wheelchair users may need to be carried over inaccessible terrain. Wheelchair accessible portable toilet with privacy tent will be available. This toilet does not have handrails. **Initial** _____
- ◆ If help is needed with bladder or bowel routine, feeding tube, or administering prescription medications attendant or family member will be present to assist. **Initial** _____

Sierra Summer Sports or Tahoe Paddle Sports:

- ◆ Weight limit is 185 lbs. for wheelchair users. Exceptions will be considered if you are fully independent and strong enough to transfer down and up about 12". **Initial** _____
- ◆ You are able to turn face-up from a face-down floating position in the water, while wearing a life vest. **Initial** _____
- ◆ If help is needed with bladder or bowel routine, feeding tube, or administering prescription medications attendant or family member will be present to assist. **Initial** _____

***In signing below, I verify that the information on pages 1 and 2 is current and accurate.
I understand this information is confidential and will be used only by Achieve Tahoe.***

Printed Name

Signature

Date