Participant Information

2018

Name: (Participant) _____ Cell Phone: _____

Email: _____Second 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