



## PARTICIPANT APPLICATION

(Please Print)

**Participation in Steamboat Adaptive Recreational Sports is subject to review and evaluation by STARS staff. If you need assistance in completing this application, please call our office and we will assist you: 970-871-5371.**

### CONTACT INFORMATION

Last Name:	First Name:	Today's date:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
		Date of Birth:	
Mailing address:	City:	State:	ZIP Code:
			County:

### PHONE NUMBERS

Home:	Work:	Cell:
Email:		Would you prefer to receive our information electronically? <input type="checkbox"/> Yes <input type="checkbox"/> No

### EMERGENCY CONTACT INFORMATION

Emergency Contact Name:	Emergency Contact Phone 1:	Emergency Contact Ph 2:	Relationship:
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### OCCUPATION HISTORY

Occupation (optional):	Employer (optional):	Are you a veteran of the US Military? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what Branch of Service?: _____
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### GUARDIAN INFORMATION

Are you your own guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If NO, please answer the following regarding your guardian:			
Last Name:	First Name:	Relationship:	
Address:	City:	State:	ZIP Code:
Phone 1:	Phone 2:	Email:	

**Send Mail To (please check one):**    Participant    Guardian    Both Participant & Guardian

### PARTICIPATION INFORMATION

Please check the activities in which you are interested in participating. For the selected activities, indicate your current skill level.			For any of the activities, please tell us what kind of adaptation or equipment you feel you may need:	
	Beginner	Intermediate	Advanced	
<input type="checkbox"/> Alpine Skiing				
<input type="checkbox"/> Snowboarding				
<input type="checkbox"/> Nordic Skiing				

Are you Right or Left Handed? <input type="checkbox"/> Right <input type="checkbox"/> Left
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In what other sports are you involved?
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## MEDICAL INFORMATION

### PHYSICIAN INFORMATION

Physician Name:

Physician Phone:

Physician Fax:

### DIAGNOSIS DETAILS

Disability/Diagnosis:

Date of Injury  
(If Applicable):Briefly describe the nature and/or cause of your disability  
(for example: auto accident, blood clot, congenital, etc.).

Weight: \_\_\_\_\_ lbs. Height \_\_\_\_\_ ft. \_\_\_\_\_ in.

### SEIZURES & ALLERGIES

Do you have seizures?  Yes  No If yes, please answer the following questions regarding your seizures:

Type of seizure:

Date of last seizure:

Are you currently  
taking medication for  
seizures?Do you have any  
allergies? Yes  No

If yes, please list.

 Yes  No

### MOBILITY

Please indicate your **primary** mode of mobility:

- Walking  
 Partial walking/partial wheelchair  
 Wheelchair – Circle one: MANUAL or POWER

Please list any mobility aides used in ambulation:

### STRENGTH & RANGE OF MOTION

Please indicate any movement or strength limitations you have. If it is not the same on both sides of your body, use the Left (L) and Right (R) choices to clarify those differences.

STRENGTH	Weak		Average		Strong		RANGE OF MOTION	Normal		Limited	
	(L)	(R)	(L)	(R)	(L)	(R)		(L)	(R)	(L)	(R)
Upper Body Strength							Upper Body Range of Motion				
Lower Body Strength							Lower Body Range of Motion				

### TONE

Do you have normal muscle tone?

 Yes  No

If NO, how would you describe your tone?

 Spastic  Athetoid  Flaccid  Other

### VISION

If you have a visual impairment, please tell us about your vision.

Visual Acuity:

Field of Vision:

Other:

### HEARING

If you have a hearing impairment, please tell us about your hearing:

## MEDICAL INFORMATION CONTINUED

PLEASE CHECK YES OR NO TO THE FOLLOWING QUESTIONS	YES	NO	DETAILS
			Use the space to below to provide details about anything for which you checked <b>YES</b> .
Is any part of your body paralyzed?			
Do you have altered hot/cold sensation?			
Do you use American Sign Language?			
Do you have difficulty speaking or communicating?			
Do others have difficulty understanding you?			
Do you have difficulty remembering things?			
Do you have difficulty following directions?			
Do you become easily frustrated?			
Do you ever verbally or physically lose control?			

PLEASE CHECK YES OR NO IF YOU HAVE HISTORY OF ANY OF THE FOLLOWING	YES	NO	DETAILS
			Use the space to below to provide details about anything for which you checked <b>YES</b> .
Asthma			
Diabetes			
Hypoglycemia			
Balance			
Dizziness			
Vision			
Bone Fracture			
Fainting			
Cardiac Disorder			
Hearing			
Shunt			If yes, where?
Rods			If yes, where?
Fused joints			If yes, where?
Other			

<b>BEHAVIORISMS</b>
Are there any challenging behaviors that would be helpful to know about?
What do you do when there are challenging behaviors?

The information contained on this application may be used internally by STARS staff and volunteer instructors.	
Please return to: <b>STeamboat Adaptive Recreational Sports</b> <b>PO Box 770208</b> <b>Steamboat Springs, CO 80477</b> <b>Fax: (970) 871-5378</b>	<b>If you email this form you need to save a copy and then email that copy to <a href="mailto:info@steamboatstars.com">info@steamboatstars.com</a>.</b>
2009/2010	

OFFICE USE ONLY		
New Participant? _____	Equipment Type _____	Date Received ___/___/___