



# PARTICIPANT INFORMATION FORM

## Telluride Adaptive Sports Program Moab Mania!

Int./Advanced Camp: September 23-28, 2011

Beginner/Int. Camp: September 30-October 5, 2011

Thank you for your interest in our upcoming Moab Mania! Off-Road Arm Bike Camp. Please fill out this registration form and return it at your earliest convenience to the return address, fax, or email.

### Participant Information (as it applies):

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_ Gender:  M  F  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone – Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_  
 Email: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shoe Size: \_\_\_\_\_  M  W T-shirt Size: \_\_\_\_\_  M  W  
 Status in US Armed Forces:  Active  Veteran  Reservist Branch:  USN  USMC  USA  USAF  Other \_\_\_\_\_  
 Rank: \_\_\_\_\_ Years of Active Duty: \_\_\_\_\_ Date of Separation from Active Duty: \_\_\_\_\_  
 Deployment Experience:  OIF  OEF  Other \_\_\_\_\_

### Guest Information (if applicable):

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Relationship to Primary Participant: \_\_\_\_\_ US Service Member?  Y  N  
 Mailing Address: \_\_\_\_\_ Gender:  M  F  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone – Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_  
 Email: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shoe Size: \_\_\_\_\_  M  W T-shirt Size: \_\_\_\_\_  M  W

### Emergency Contact Information:

Emergency Contact:		Relation:
<input type="checkbox"/> Home:	<input type="checkbox"/> Cell:	<input type="checkbox"/> Work:

\*\*\*please check box for preferred contact phone\*\*\*



# PARTICIPANT INFORMATION FORM

## Disability & Medical Information:

\*\*If your disability/injury has occurred within the last 12 months or if you have had surgery within the last 12 months, please attach a physician's release.\*\*

What is your disability?		
Date of Onset:	<input type="checkbox"/> Onset Date Unknown	
Current Physician:	Phone Number:	
Medications:	What are they for?	Any changes in last 3 months?
1)		
2)		
3)		
4)		
5)		
Do you have seizures?	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, last seizure date: _____ Type: _____
Frequency of seizures?	On seizure Medication? <input type="checkbox"/> Y <input type="checkbox"/> N	
Please list any allergies you may have:		
Are any of your body parts susceptible to cold, heat and/or impact:	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, please list: _____
Do you have any cardiac problems? If yes, please describe:		
Do you experience pain?	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, location and severity of pain: _____
Communication:	<input type="checkbox"/> Verbal <input type="checkbox"/> Non-verbal <input type="checkbox"/> Sign Language <input type="checkbox"/> Braille <input type="checkbox"/> Electronic Assist <input type="checkbox"/> Other:	
Are you currently under a doctor's care for any condition:	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, please explain: _____
Has your doctor restricted you from any activity or sport?	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, please explain: _____
Within the past 6 mths, have you had any injury or surgery in your back, spinal cord, or hips?	<input type="checkbox"/> Y <input type="checkbox"/> N	
If yes, please explain: _____		
Hearing:	<input type="checkbox"/> Intact <input type="checkbox"/> Impaired:	Vision: <input type="checkbox"/> Intact <input type="checkbox"/> Impaired:
Please list dietary restrictions:		
Are you right or left hand dominate? <input type="checkbox"/> Right <input type="checkbox"/> Left		
Do you have decreased strength or sensation in your upper extremities (arms)? <input type="checkbox"/> Y <input type="checkbox"/> N		
If yes, which side and please explain: _____		
Will you need any type of adaptation device to hold objects (i.e. paddle, handle bar, etc)? <input type="checkbox"/> Y <input type="checkbox"/> N		
Do you have upper or lower extremity limitation that may affect your activity participation? <input type="checkbox"/> Y <input type="checkbox"/> N		
If yes, where and please explain: _____		
Are you able to sit upright without any supportive device? <input type="checkbox"/> Y <input type="checkbox"/> N		Are you able to swim? <input type="checkbox"/> Y <input type="checkbox"/> N
Have you been cleared to be in the water- Shower? <input type="checkbox"/> Y <input type="checkbox"/> N Submerged? <input type="checkbox"/> Y <input type="checkbox"/> N		



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**Mobility:**

Are you able to walk? <input type="checkbox"/> Y <input type="checkbox"/> N
If yes, how far of a distance?
what percentage of a day do you walk? <input type="checkbox"/> 25% <input type="checkbox"/> 50% <input type="checkbox"/> 75% <input type="checkbox"/> full-time walking ability
are you limited by <input type="checkbox"/> fatigue <input type="checkbox"/> pain <input type="checkbox"/> skin issues
I am able to walk on <input type="checkbox"/> flat surfaces <input type="checkbox"/> inclines/declines <input type="checkbox"/> rocky uneven surfaces <input type="checkbox"/> all
Do you use a mobility device? <input type="checkbox"/> Y <input type="checkbox"/> N   If yes, please check the device(s) you use?
<input type="checkbox"/> wheelchair <input type="checkbox"/> walker <input type="checkbox"/> cane <input type="checkbox"/> crutches <input type="checkbox"/> prosthetic <input type="checkbox"/> orthotic <input type="checkbox"/> other:
If using a wheelchair, please check the percentage of the day that you use the wheelchair:
<input type="checkbox"/> 0% <input type="checkbox"/> 25% <input type="checkbox"/> 50% <input type="checkbox"/> 75% <input type="checkbox"/> full-time wheelchair user
I am able to transfer to/from my wheelchair to: <input type="checkbox"/> van/car/bus <input type="checkbox"/> multilevel surface <input type="checkbox"/> bike/raft
Are you independent with your transfers? <input type="checkbox"/> Y <input type="checkbox"/> N   If not, please check level of assistance you need?
<input type="checkbox"/> minimal (contact guard) <input type="checkbox"/> moderate (pivot transfer) <input type="checkbox"/> maximum (2 person lift)
Do you use a shower chair? <input type="checkbox"/> Y <input type="checkbox"/> N   If yes, I will <input type="checkbox"/> bring my own <input type="checkbox"/> need a shower stool
Are you independent with daily activities such as bathing, bathroom, dressing, cathing, etc? <input type="checkbox"/> Y <input type="checkbox"/> N
If not, please explain the assistance you require:
Are you able to turn from a face down to a face up position in the water (water safe)? <input type="checkbox"/> Y <input type="checkbox"/> N

**Amputation:**

Status of Injury: <input type="checkbox"/> Primary Disability <input type="checkbox"/> Secondary Condition
Level of Amputation: _____ Date of Amputation: _____
Please describe your means of mobility (i.e. prosthesis, wheelchair, none, etc.):
<small>*please note, we will not be held responsible if the prosthesis becomes damaged or broken while participating in our program*</small>
Please check all characteristics that apply as a result of your amputation:
<input type="checkbox"/> weight gain <input type="checkbox"/> skin breakdown on residual limb(s) <input type="checkbox"/> limb pain <input type="checkbox"/> depression <input type="checkbox"/> decreased physical activity
<input type="checkbox"/> muscle loss <input type="checkbox"/> back/hip concerns <input type="checkbox"/> decrease bone density <input type="checkbox"/> other:
Of those checked above, please comment on any you feel we need to know more about:
Please list ALL safety precautions you take to protect the amputated limb against cold and falls:
Please describe what devices/methods you use to prevent skin breakdown or pressure ulcers:



# PARTICIPANT INFORMATION FORM

## Combat Stress:

Do you have panic attacks? <input type="checkbox"/> Y <input type="checkbox"/> N	Do you have flashbacks? <input type="checkbox"/> Y <input type="checkbox"/> N
Are you sensitive to loud noises? <input type="checkbox"/> Y <input type="checkbox"/> N	Do crowds make you feel anxious? <input type="checkbox"/> Y <input type="checkbox"/> N
Do you get angry easily? <input type="checkbox"/> Y <input type="checkbox"/> N	Are you hyper-vigilant? <input type="checkbox"/> Y <input type="checkbox"/> N
Do you isolate yourself? <input type="checkbox"/> Y <input type="checkbox"/> N	You get anxious easily? <input type="checkbox"/> Y <input type="checkbox"/> N
How do you handle stress?	
How can we best support you should you become anxious, fearful, angry, etc?	

## Traumatic Brain Injury (TBI):

Have you sustained a traumatic brain injury? <input type="checkbox"/> Y <input type="checkbox"/> N	
Status of Injury: <input type="checkbox"/> Primary Disability <input type="checkbox"/> Secondary Condition	Date of Injury:
What was the cause of your TBI? <input type="checkbox"/> Blast Injury <input type="checkbox"/> Motor Vehicle Injury <input type="checkbox"/> Other:	
Severity of Injury: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe	
Has your TBI affected you in any of the following ways?	
Short-term memory impairment? <input type="checkbox"/> Y <input type="checkbox"/> N	Decreased attention span? <input type="checkbox"/> Y <input type="checkbox"/> N
Problem-solving difficulties? <input type="checkbox"/> Y <input type="checkbox"/> N	Inability to concentrate? <input type="checkbox"/> Y <input type="checkbox"/> N
Decreased balance? <input type="checkbox"/> Y <input type="checkbox"/> N	Vestibular impairment? <input type="checkbox"/> Y <input type="checkbox"/> N
Do you get dizzy? <input type="checkbox"/> Y <input type="checkbox"/> N	Do you get motion sickness? <input type="checkbox"/> Y <input type="checkbox"/> N
Do you have difficulty walking? <input type="checkbox"/> Y <input type="checkbox"/> N	Do you have difficulty running? <input type="checkbox"/> Y <input type="checkbox"/> N
Impulsive/decrease ability to filter what I say and/or do? <input type="checkbox"/> Y <input type="checkbox"/> N	
Please explain any of the items that you have checked yes to:	
Please comment on any characteristic in which you feel we need to know more about:	
Do you have headaches? <input type="checkbox"/> Y <input type="checkbox"/> N   If yes, how often do they occur?	
What triggers your headaches?	
On a scale of 1 (mild) to 10 (severe), how severe are your headaches?	
How do you treat your headaches? <input type="checkbox"/> medication <input type="checkbox"/> rest <input type="checkbox"/> other:	



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### Other Medical Conditions:

Please check any other conditions that may apply and you have not already explained:
<input type="checkbox"/> poor circulation <input type="checkbox"/> sensory loss <input type="checkbox"/> autonomic dysreflexia <input type="checkbox"/> cardiovascular problems <input type="checkbox"/> diabetes
<input type="checkbox"/> lack of stamina <input type="checkbox"/> thermal regulation problems <input type="checkbox"/> respiratory problems <input type="checkbox"/> altitude related problems
<input type="checkbox"/> other:
If you checked any of the above conditions, please give an explanation:

### Outdoor Experience:

Activity	Previous Experience Before Injury	Previous Experience After Injury	Interested in Participating?	Level of Ability Post Injury?
Rock climbing	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> beg <input type="checkbox"/> int <input type="checkbox"/> adv
Road cycling	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> beg <input type="checkbox"/> int <input type="checkbox"/> adv
Mountain biking	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> beg <input type="checkbox"/> int <input type="checkbox"/> adv
Camping	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> beg <input type="checkbox"/> int <input type="checkbox"/> adv
Hiking	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> beg <input type="checkbox"/> int <input type="checkbox"/> adv
Kayaking	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> beg <input type="checkbox"/> int <input type="checkbox"/> adv
Rafting	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> beg <input type="checkbox"/> int <input type="checkbox"/> adv
Canoeing	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> beg <input type="checkbox"/> int <input type="checkbox"/> adv
Fishing	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> beg <input type="checkbox"/> int <input type="checkbox"/> adv
Horseback riding	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> beg <input type="checkbox"/> int <input type="checkbox"/> adv
Jeeping	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> beg <input type="checkbox"/> int <input type="checkbox"/> adv
ATVing	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> beg <input type="checkbox"/> int <input type="checkbox"/> adv

### Lodging & Travel Preferences and Goals:

Arranged 'housing' for this trip is camping in an established, accessible campground and we hope to make you as comfortable as possible.

List <b>first</b> choice of departure airport near your city:
List <b>second</b> choice of departure airport near your city:
I will be traveling with a <input type="checkbox"/> wheelchair and/or <input type="checkbox"/> service animal
For accommodations, I prefer a <input type="checkbox"/> single / <input type="checkbox"/> double room with a <input type="checkbox"/> twin-sized / <input type="checkbox"/> queen / <input type="checkbox"/> king bed.
Is there anything that would make your stay more comfortable: (accessibility, shower, etc)

Please list any goals that you would like to achieve while participating in this event:
Social:
Physical:
Recreational:



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\*High output recreation in the desert environment of Moab, Utah presents a unique set of challenges for all individuals. Maintaining a high level of hydration and electrolyte level in your body along with staying shaded and cooled down from the sun are VERY important factors on this trip. Though we do our best to time our rides in accordance with the coolest parts of the day and provide plenty of reserve fluids and cooling tactics, not all individuals can combat the intensity of the environment. Please bring plenty of sunscreen, water bottles, and YOUR preferred methods of staying well hydrated, fed, and cool. In the event of an emergency, TASP carries a small amount of general medications to assist in first-aid incidents. Though these are merely supplemental, please know the best practice in first aid is taking care of your body and mind before any uncomfortable situation can occur.

If the need arises, do you give permission for TASP Instructors to administer the following medications to the participant:

- Y N – Tylenol
- Y N – Aspirin (Bayer)
- Y N – Ibuprofen (Advil, Motrin)
- Y N – Anti-acid (heartburn)
- Y N – Pepto-Bismol
- Y N – Tinactin (fungal cream)
- Y N – Antibiotic Cream
- Y N – Hydrocortisone (soothes itching)
- Y N – Benadryl (allergic reaction)
- Y N – Epinephrine (severe allergic reaction)

By signing here, you give your consent for TASP to administer medications circled with Y:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Initials

Additional Notes: