



# PARTICIPANT INFORMATION FORM

## Telluride Adaptive Sports Program Participant Registration Form Summer Adventure Week! for Wounded Warriors June 5 – 8, 2011 (Travel Dates: June 4 & 9)

Thank you for your interest in our upcoming Summer Adventure Week! Please fill out this registration form and return it at your earliest convenience to the return address, fax, or email listed on the last page of the application. TASP is able to provide travel, ground transportation, lodging, program costs and some food costs for each participant. Participants are responsible for some meals and incidentals.

### Participant Information:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ Gender:  M  F  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone – Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_  
Email: \_\_\_\_\_ Fax: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shoe Size: \_\_\_\_\_ MW T-shirt Size: \_\_\_\_\_ MW  
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: \_\_\_\_\_ MW T-shirt Size: \_\_\_\_\_ MW

### 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\*\*\*

Please email, mail, or fax all 5 pages of this form to TASP at:  
EMAIL: director@tellurideadaptivesports.org FAX: 970.728.3593  
MAIL: PO Box 2254, Telluride, CO 81435 \*\* Please call 970.728.3524 with questions.



# 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 effect 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"/> ski bucket/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.):	
*please note, we will not be held responsible if the prosthesis becomes damaged or broken while participating in our program*	
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:	



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## 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

<b>Please list top 3 activities you are interested in participating in?</b>

## Lodging & Travel Preferences and Goals:

\*\*Although there is no guarantee, we will do our best to meet your lodging and travel preferences.\*\*

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: