



**Telluride Adaptive Sports Program  
Participant Registration Form  
Summer Adventure Week  
for Wounded Warriors  
June 6-10, 2010  
(Travel days June 5&11)**

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 and their guest. Participants are responsible for some meals and incidentals.

**PARTICIPANT INFORMATION**

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **St:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home Phone:** (\_\_\_\_) \_\_\_\_\_ **Cell Phone:** (\_\_\_\_) \_\_\_\_\_

**Email:** \_\_\_\_\_

**Phone:** (\_\_\_\_) \_\_\_\_\_ **Fax:** (\_\_\_\_) \_\_\_\_\_

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

**ADDITIONAL GUEST INFORMATION**

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Relationship to primary participant:** \_\_\_\_\_

**Is your guest a U.S. Service Member:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **St:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home Phone:** (\_\_\_\_) \_\_\_\_\_ **Cell Phone:** (\_\_\_\_) \_\_\_\_\_

**Email Address:** \_\_\_\_\_

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

**EMERGENCY CONTACT INFORMATION**

Emergency Contact: \_\_\_\_\_ Relationship to participant: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

**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.*

Disability (please describe or classify):

\_\_\_\_\_

\_\_\_\_\_

**Physical Limitations:** (please describe or illustrate any physical limitations. For example--range of motion, muscle tone, strength, extent of hearing loss, range or clarity of vision)\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date/Onset of disability: \_\_\_\_\_

**Communication** (please circle):

Verbal      Non-Verbal      Sign-Language      Braille      Electronic Assistance

**Mobility**(please circle):    Walking      Walking w/Guide      Cane/Crutches      Braces      Wheelchair

**Are you currently under a doctor's care for any condition?** Yes No

**If yes, please explain:**

\_\_\_\_\_

\_\_\_\_\_

**Has your doctor restricted you from any activity or sport?** Yes No

**If yes, please explain:**

\_\_\_\_\_

\_\_\_\_\_

**Within the past six months, have you had any injury, or surgery on your back, spinal cord or hips?**

Yes No

**If yes, please explain:**

\_\_\_\_\_

\_\_\_\_\_

**Do you experience seizures?** Yes No

**If yes, please list date and type of most recent seizure:**

\_\_\_\_\_

\_\_\_\_\_

Do you have any other special medical conditions that we should be aware of? Yes No

If yes, please explain:

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Are you currently taking any medications? Yes No

If yes, please list:

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Current Physician : \_\_\_\_\_ Phone number: (\_\_\_\_) \_\_\_\_\_

Please circle any conditions that may apply:

Poor Circulation	Sensory Loss	Autonomic Dysreflexia
Cardiovascular Problems	Lack of Stamina	Thermal Regulation Problems
Diabetes	Respiratory Problems	

**MILITARY INVOLVEMENT INFORMATION**

Years served in U.S. Military: \_\_\_\_\_ What Branch: \_\_\_\_\_

Job Title: \_\_\_\_\_ Current Status: \_\_\_\_\_

Have you attended other recreational programs for disabled U.S. Service Members?

If yes, please list where and dates attended:

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**LODGING/ACCOMMODATIONS**

*Please provide the following information so we may do our best to meet all of your accommodation needs!*

Type of accommodations: Single Double

Do you prefer: (2) Twin-size beds King-size bed

Is there anything that would make your stay more comfortable:

(wheel chair accessibility, shower stool, etc.)

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**TRAVEL INFORMATION**

Largest major airport near your city of departure: \_\_\_\_\_

Will you be traveling with a wheel chair or service animal?: \_\_\_\_\_

*Please email, fax or mail all three pages of this form to:  
director@tellurideadaptivesports.org or FAX: 970-728-3593 or  
Mail: TASP, P.O. Box 2254, Telluride, CO 81435*