

Summer 2012 - Participant Information

OFFICE USE ONLY
cc on file?

Date Initials

To TASP: New Returning

Participant Name: _____ Date of Birth: _____

Name of Parent/Guardian: _____ Group/School Name: _____

Mailing Address: _____ Gender: M F

City: _____ State: _____ Zip: _____ County (CO only): _____

Phone(s) Home: _____ Cell: _____ Work: _____

Email: _____ Fax: _____

Height: _____ Weight: _____ Shoe Size: _____ M W youth

Emergency Contact:

Relation:

Home:

Cell:

Work:

please check box for preferred contact phone

Activity Interest

- Hiking Mountain Biking Road Cycling Rock Climbing Horseback Riding Fishing
 Camping Jeeping ATVing Rafting – river Kayaking – river Kayaking – lake
 Canoeing – lake Special Olympics Bocce Ball Other _____

If previous experience in any activity, please tell us when and where: _____

Disability & Medical Information

Disability: _____ Date of Onset/Accident¹: _____

If **physical**, describe (level of injury, level of function, mobility equipment used, VI? level of vision, glasses/contacts, HI? need ASL interpreter?, affected body parts, etc): _____

If **cognitive**, describe (level of cognition, stressors, motivators, etc): _____

Allergies (food, meds, *reaction*) or dietary requirements: _____

Has the participant **ever had a seizure**? yes/no Are they controlled? _____

If so, when was the last one? _____ Describe, what type? _____

¹ If it has been less than one year from the date of accident, illness or injury, please provide us with written permission from your doctor to participate as this is a TASP guideline for safe participation.

It is TASP's policy to apply **sunscreen** to participants as deemed necessary.

If you do NOT want TASP to apply sunscreen to the participant, please initial here _____. Medically, if the participant requires a specific sunscreen product, please bring that product on all TASP trips and name that product here: _____

All participants, list all **medications**, dosage, what for and when taken: _____

Is the participant able to self-administer medication? yes no Remember timing of medication? yes no
If not, please contact the TASP Program Staff to determine a plan to administer the medication.

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

- | | | |
|---|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N – Tylenol | <input type="checkbox"/> Y <input type="checkbox"/> N – Pepto-Bismol | <input type="checkbox"/> Y <input type="checkbox"/> N – Hydrocortisone (soothes itching) |
| <input type="checkbox"/> Y <input type="checkbox"/> N – Aspirin (Bayer) | <input type="checkbox"/> Y <input type="checkbox"/> N – Tinactin (fungal cream) | <input type="checkbox"/> Y <input type="checkbox"/> N – Benadryl (allergic reaction) |
| <input type="checkbox"/> Y <input type="checkbox"/> N – Anti-acid (heartburn) | <input type="checkbox"/> Y <input type="checkbox"/> N – Antibiotic Cream | <input type="checkbox"/> Y <input type="checkbox"/> N – Epinephrine (severe allergic reaction) |
| <input type="checkbox"/> Y <input type="checkbox"/> N – Ibuprofen (Advil, Motrin) | | |

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

Do you have a prescribed epi-pen? Y N If yes, you are required to have it with you on all TASP trips.

Does the participant have a **shunt**? yes no

Describe any **medical concerns**, surgeries, illnesses, or injuries we should be aware of in case of an emergency: _____

List body parts **susceptible to heat, cold, impact** and what helps regulate this (spray bottle, etc): _____

On a scale of 1-5, please rate - **Upper body strength** (poor) 1 2 3 4 5 (excellent)

Balance (poor) 1 2 3 4 5 (excellent)

Describe any physical weakness: _____

Do you need **assistance** in the following areas: eating, bowel/bladder, dressing, attendant care needs, sleeping or sleepwalking, or other special needs? Please describe so we may address / plan appropriately: _____

Additional Information

If boating, will the participant need **special boat seating**? yes no

If yes, please elaborate: Rigid Arm supports Crazy Creek Other: _____

Swimming Ability: Afraid of Water Can't Swim Can Float
Can Swim at Least 50 Yards Swim Well Love the Water

Do you have any **fears** (heights, water, speed)? Y N

If yes, please describe: _____

List **other activities** the participant participates in: _____

How does the participant handle **stress** and what helps minimize it? _____

What **motivates** the participant? What is the motivation for participating? _____

What are the participants goals while at TASP? _____

**Due to liability, TASP is not able to provide services to individuals who are under the influence of alcohol for any time during their scheduled activity. TASP reserves the right to immediately end the activity and provide no refund, if it is determined that a participant is not abiding by these terms.