

# Participant Information 2011/2012

OFFICE USE ONLY  
cc on file?

Date \_\_\_\_\_ Initials \_\_\_\_\_

Own Pass  Need Ticket

To TASP:  New  Returning

Name of Participant: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

Group/School Name: \_\_\_\_\_

Email address: \_\_\_\_\_ Gender:  M  F

Address: \_\_\_\_\_ County (CO only): \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Fax: \_\_\_\_\_

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

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_

Home: \_\_\_\_\_  Cell: \_\_\_\_\_  Work: \_\_\_\_\_

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

Requested Lesson Dates and Type: \_\_\_\_\_

Local Lodging Name: \_\_\_\_\_ Local Phone: \_\_\_\_\_

Preferred Payment Method (please check):  Visa  MasterCard  AmEx  Check  Cash

## Disability & Medical Information

Disability: \_\_\_\_\_ Date of Onset/Accident<sup>1</sup>: \_\_\_\_\_

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): \_\_\_\_\_

**All participants**, please list any **allergies** (food, meds, *reaction*) or dietary requirements: \_\_\_\_\_

Has the participant **ever had a seizure**? \_\_\_\_\_ If so, when was the last one? \_\_\_\_\_

Describe, what type? \_\_\_\_\_ Are they controlled? \_\_\_\_\_

<sup>1</sup> 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.

\*\*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.

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 any **medications**, dosage, what for: \_\_\_\_\_

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: \_\_\_\_\_

Does the participant have a shunt?  yes  no

Describe any medical concerns we should be aware of in case of an emergency: \_\_\_\_\_

Any recent injuries, illnesses, *surgeries*, or skin breakdowns in the last year? Provide dates and specifics: \_\_\_\_\_

List body parts susceptible to cold, heat, impact: \_\_\_\_\_

List other activities the participant participates in: \_\_\_\_\_

What are the participants goals while at TASP: \_\_\_\_\_

How did you hear about the program: \_\_\_\_\_

### Snowsport Information

Height: \_\_\_\_\_ Weight<sup>2</sup>: \_\_\_\_\_ Shoe Size: \_\_\_\_\_

Skied before?  yes  no, # of times \_\_\_\_\_ Number of times since disability \_\_\_\_\_

Skied Telluride before?  yes  no Where have you skied (areas/programs)? \_\_\_\_\_

If skied with TASP before, name of previous instructor(s): \_\_\_\_\_

Terrain skied since disability:  green  double green  blue  double blue  black  double black  bumps  Nastar

What method do you use:  alpine ski  snowboard  mono-ski  bi-ski  dual-ski  ski bike

(check all that apply)  3 track  4 track  VI guide  slider  don't know

Need rental equipment?  yes  no

Need adaptive rental equipment?  yes  no

If yes, what equipment have you used in the past? \_\_\_\_\_

<sup>2</sup> Due to equipment limitations and the safety of participants and instructors, we have a 200 lbs weight limit for all sit down participants.