

PARTICIPANT REGISTRATION FORM

PARTICIPANT INFORMATION				
First Name:		Middle Initial:	Last Name:	
Address:				
City:		State:	Zip:	
Mobile Phone:		Alternative Phone:		
Email Address:				
Date of Birth:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Prefer Not to Answer <input type="checkbox"/> Other	Height (ft,in):	Weight (lbs):	Shoe Size:
Ethnicity: <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Prefer Not to Answer <input type="checkbox"/> Other				
(If applicable) Military Service: <input type="checkbox"/> Active Military Duty <input type="checkbox"/> Reserve <input type="checkbox"/> Veteran <input type="checkbox"/> N/A			Years of Service:	
(If applicable) Branch of Service:			Rank:	
PARENT/LEGAL GUARDIAN INFORMATION (IF PARTICIPANT IS A MINOR OR LEGALLY DEPENDENT)				
First Name:		Last Name:		
Address (if different than above):				
City:		State:	Zip:	
Home Phone:	Mobile:	Work:		
Email Address:		Relationship:		
EMERGENCY CONTACT				
First Name:		Last Name:		
Relationship to Participant:				
Home Phone:	Mobile:	Work:		
MEDICAL INFORMATION				
Disability/Diagnosis:				
Date of injury or onset:		Do you use any assistive devices? (wheelchairs, prosthetics, crutches, communication devices, etc.)		

If you use a wheelchair, are you independent with your transfers? Y N *If NO, please describe your needs:*

Are you currently taking any medications? Y N *If YES, please list medication type and reason:*

Do you have any dietary restrictions? Y N *If YES, please list:*

Do you have any allergies (latex, medication, insects, food)? Y N *If YES, please list:*

Do you have a history of seizures? Y N *If YES, please list type, frequency, date of last seizure:*

Have you had surgery in the last six months? Y N *If YES, please explain:*

PLEASE INDICATE YES OR NO TO EACH QUESTION. IF YES, PLEASE DESCRIBE TYPE AND SEVERITY

Brain Injury	<input type="checkbox"/> Y <input type="checkbox"/> N	
Post-Traumatic Stress	<input type="checkbox"/> Y <input type="checkbox"/> N	
Blind or low vision	<input type="checkbox"/> Y <input type="checkbox"/> N	
Deaf or hard of hearing	<input type="checkbox"/> Y <input type="checkbox"/> N	
Limited range of motion in any limbs	<input type="checkbox"/> Y <input type="checkbox"/> N	
Difficulty with balance	<input type="checkbox"/> Y <input type="checkbox"/> N	
Spinal stabilization devices	<input type="checkbox"/> Y <input type="checkbox"/> N	
Paralysis (please indicate body part)	<input type="checkbox"/> Y <input type="checkbox"/> N	
Sensitivity to hot or cold	<input type="checkbox"/> Y <input type="checkbox"/> N	
Difficulty speaking or communicating	<input type="checkbox"/> Y <input type="checkbox"/> N	
Difficulty remembering or following directions	<input type="checkbox"/> Y <input type="checkbox"/> N	

Emotional and/or behavioral concerns we should know about	<input type="checkbox"/> Y <input type="checkbox"/> N	
Personal care or independence concerns	<input type="checkbox"/> Y <input type="checkbox"/> N	
Cognitive or developmental delay	<input type="checkbox"/> Y <input type="checkbox"/> N	
Heart/Cardiac condition	<input type="checkbox"/> Y <input type="checkbox"/> N	
Respiratory condition	<input type="checkbox"/> Y <input type="checkbox"/> N	

Please list any other medical conditions or concerns that may affect your ability to participate (family history of medical conditions, prone to dislocations, brittle bones, etc.):

PARTICIPATION INFORMATION

Please select the sports/activities you would like to register for:

<input type="checkbox"/> Sport/Activity	<input type="checkbox"/> Sport/Activity	<input type="checkbox"/> Sport/Activity	<input type="checkbox"/> Sport/Activity
<input type="checkbox"/> Sport/Activity	<input type="checkbox"/> Sport/Activity	<input type="checkbox"/> Sport/Activity	<input type="checkbox"/> Sport/Activity

Have you participated in any of the above sports/activities before? Y N *If YES, please list type and last date you participated in the sport/activity:*

What are your sport or activity goals?

Will a caregiver be accompanying you? If yes, please list name, email address, and phone number:

Please provide any additional information that will help us create a successful experience for you:

By signing below, I certify all information is accurate and truthful to the best of my knowledge.

Printed Name:	Date:
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Signature:

If the participant is under 18 or legally dependent, this section must also be completed:

Parent/ Legal Guardian Printed Name:	Date:
Parent/Legal Guardian Signature:	Relationship: