Participant Information Form

Participation in Steamboat Adaptive Recreational Sports is subject to review and evaluation by STARS staff. Please call our office at 970-870-1950 if you need assistance in completing this application. Your information is important to us so that we may provide the best possible service to you so please print clearly.

CLIENT INFORMATION

Last name:	First name:	Date of birth:	Sex: ❒ M ❒ F
Client cell phone (must have if independent):	Home phone:	Today's date:	

PARENT / GUARDIAN INFORMATION

Last name:	First name:	Relationship to client:

EMERGENCY CONTACT INFORMATION: Please answer if different from parent/guardian and traveling with client

Name:	Phone (preferably cell):	Relationship	Lodging name/phone:

HEALTH HISTORY

Height: _____ft. _____in. Weight: _____lbs.

*Due to personnel safety standards and equipment weight limits, we cannot accommodate sit skiers over 200lbs. For alternate options, please call the STARS office.

History of Seizures: ❒ Y ❒ N Seizure type: ❒ Petite ❒ Mal ❒ Grand Mal ❒ Other _____ Seizure in the past 24mths: ❒ Y ❒ N

Allergies? ❒ Y ❒ N Type of Allergies: _____ Do you carry an Epipen? ❒ Y ❒ N

Medications: _____ Side effects of medications: _____

Please note, STARS CANNOT administer medications

Assistance needed using the bathroom? ❒Y ❒N ***Please note, STARS CANNOT assist with the personal care of participants***

Name of caregiver who will assist:_____ Phone: _____

Food or dietary restrictions:_____

DISABILITY (Check boxes that apply)

Disability	Subgroup (Check subgroup that corresponds with disability)
❒Autism spectrum disorder	
❒Cancer	
❒Cognitive	❒ ID ❒ DD ❒ Down Syn. ❒ ADD ❒ ADHD ❒ Bipolar ❒ Other_____
❒Deaf/hard of hearing	❒ Complete left ❒ Complete right ❒ Partial left ❒ Partial right
❒ Medical	❒ Diabetes ❒ Heart defect ❒ Arthritis ❒ Other_____
❒Neuromuscular (affects muscles or nervous system)	❒ CP ❒ Balance disorder ❒ TBI ❒ Spina bifida ❒ Other_____ ❒ SCI Level: ❒C1-T1 ❒T1-T6 ❒T7-T12 ❒L1-L5 ❒S1-S5 ❒Complete ❒Incomplete
❒Orthopedic	❒ Amputee Please indicate _____ ❒ Growth Please indicate _____ ❒ Fused joints Please indicate _____
❒Vision impairment	❒ Complete left ❒ Complete right ❒ Partial left ❒ Partial right

If you checked more than one disability above, please indicate which is considered your primary and secondary disability:

Primary: _____

Secondary: _____

The information provided on this application will be used internally by STARS staff and volunteer instructors. Only contact information will be shared with Steamboat Ski & Resort Corp for marketing purposes.

❒ I would like to opt out of STARS mailing list

STARS will complete information to right

Participant name

Contact name/cell number

SPECIFIC DISABILITY DETAILS

Please describe how your disability affects you:

Date of Injury (if applicable):

PARTICIPATION INFORMATION

Please check the activities in which you are interested in participating. Indicate your current skill level or leave blank if you do not know.

Winter	Never ever	Beginner (greens)	Intermediate (blues)	Advanced (blacks)
❒ Alpine skiing				
❒ Snowboarding				
❒ Snow shoeing				
❒ Snow biking				
❒ Nordic				
❒ Other				

Summer

❒Cycling	❒Fishing	❒ Other
❒Mt. biking	❒Waterski/wakeboard	
❒Hiking	❒Paddleboard	
❒Kayak/canoe	❒Whitewater rafting	
❒Camping	❒Horseback riding	

STRENGTH & RANGE OF MOTION

Please indicate any movement or strength limitations you have.
If it not the same on both sides of you body, us the left (l) and right (r) choices to clarify

Strength	Weak	Average	Strong	Range of Motion	Limited	Normal
Upper body strength	❒ L ❒ R	❒ L ❒ R	❒ L ❒ R	Upper body range	❒ L ❒ R	❒ L ❒ R
Lower body strength	❒ L ❒ R	❒ L ❒ R	❒ L ❒ R	Lower body range	❒ L ❒ R	❒ L ❒ R

Do you have normal muscle tone? ❒ Y ❒ N

If no, how would you describe your muscle tone? ❒ Spastic ❒ Athethoid ❒ Flaccid ❒ Other _____

Mobility: ❒ Walks independently ❒ Walks w/assistive device ❒ Manual wheelchair ❒ Power wheelchair

Transfer ability: ❒ Transfers independently ❒ Transfer self w/assistance ❒ Can bear weight with assistance
❒ Cannot bear weight ❒ No ability to self-transfer

MEDICAL INFORMATION

Check "Yes" or "No" to the following questions	Yes	No	Please explain any "Yes" answers
Post-Traumatic Stress?			
Sensitivity to hot/cold?			
Do you use ASL or a communication device?			
Do you have difficulty speaking or communicating?			
Difficulty with balance?			
Difficulty remembering things or following directions?			
Any type of paralysis?			
Wear any sort of spinal stabilization?			
Personal care or independence concerns?			
Do you become easily frustrated? If so, what are your triggers?			
Do you ever verbally or physically lose control? If so, how can we help diffuse the situation?			

STARS will complete information to right

Participant name

Contact name/cell number

Check "Yes" or "No" if you have history of any of the following conditions	Yes	No	Please explain any "Yes" answers
Asthma			
Diabetes			
Hypoglycemia			
Balance			
Dizziness			
Bone Fractures			
Fainting			
Shunt			If yes, where?
Rods			If yes, where?

Please list any other medical conditions or concerns not mentioned above:

ACKNOWLEDGEMENT

I certify that the information provided in this form is true and correct to the best of my knowledge.

Printed Name:	Date:
Signature:	

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

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

PLEASE RETURN FORMS TO:
Steamboat Adaptive Recreational Sports
Email: info@steamboatstars.com / **Fax:** (970) 870-1970

OFFICE USE ONLY

Date Form Received ____/____/____ Form Reviewed by _____Date ____/____/____