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: ❑ M ❑ F ❑ Prefer Not to Answer ❑ Other	Height (ft,in):	Weight (lbs):	Shoe Size:
Ethnicity: ❑ Asian ❑ Black/African American ❑ Caucasian ❑ Hispanic/Latino ❑ Native American ❑ Pacific Islander ❑ Prefer Not to Answer ❑ Other				
(If applicable) Military Service: ❑ Active Military Duty ❑ Reserve ❑ Veteran ❑ 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:		
Mobile Phone:	Alternative Phone:	Work:		
Email Address:	Relationship:			
EMERGENCY CONTACT				
First Name:	Last Name:			
Relationship to Participant:				
Mobile Phone:	Alternative Phone:	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 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	❑ Y ❑ N	
Post-Traumatic Stress	❑ Y ❑ N	
Blind or low vision	❑ Y ❑ N	
Deaf or hard of hearing	❑ Y ❑ N	
Limited range of motion in any limbs	❑ Y ❑ N	
Difficulty with balance	❑ Y ❑ N	
Spinal stabilization devices	❑ Y ❑ N	
Paralysis (please indicate body part)	❑ Y ❑ N	
Sensitivity to hot or cold	❑ Y ❑ N	
Difficulty speaking or communicating	❑ Y ❑ N	
Difficulty remembering or following directions	❑ Y ❑ N	

Emotional and/or behavioral concerns we should know about	❑ Y ❑ N	
Personal care or independence concerns	❑ Y ❑ N	
Cognitive or developmental delay	❑ Y ❑ N	
Heart/Cardiac condition	❑ Y ❑ N	
Respiratory condition	❑ Y ❑ 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:			
❑ Sport/Activity	❑ Sport/Activity	❑ Sport/Activity	❑ Sport/Activity
❑ Sport/Activity	❑ Sport/Activity	❑ Sport/Activity	❑ 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:
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: