



2009-2010



Office Use: Check # _____

Paid Date _____ Initial _____

Student / Participant Registration & Membership Information

The information gathered below and on the other side will help us develop the best experience for the participant. Please complete as accurately as possible. (please print)

Group Name (if appl) _____

Participant Information

New Participant _____ Returning Participant (# of yrs.) _____

Name: _____ DOB: _____ Sex _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Mobile Phone: (____) _____

E-mail address: _____

Local Address or Accomodation: _____ Phone _____

Name of accompanying parent, guardian, group leader (if appl) _____

Are you a veteran of the military? Yes/no Years of service and branch _____

Fitting Information

Height ____ ft. ____ in.

Weight _____ lbs.

Shoe Size _____ US

Do you require rental equipment?

YES No

Emergency Contact Information

Name: _____ Relationship to Participant: _____

Address: _____ City _____ State _____ Zip _____

Phone # _____ Cell Phone # _____ Work Phone # _____

Disability & Medical Information

Disability (please describe or classify): _____

Physical Limitations: please describe or illustrate any physical limitations:
(range of motion, muscle tone, strength, extent of hearing loss, range or clarity of vision)

Communication: (circle) Verbal Non-Verbal Sign-Language Braille Electronic Assistance

Mobility /Assistance (please circle): Walking Walking(w)Guide Cane/Crutches Braces Wheelchair Electric Wheelchair

Cognitive / Behavioral /Emotional Information (If applicable). Below, please circle all that apply to the participant

- | | | | |
|-------------------|----------------------|----------------------|----------------|
| Frustration | Impulsivity | Aphasia (expressive) | Acting out |
| Hostility | Speech Difficulties | Aphasia (receptive) | Aggression |
| Confusion | Peceptual Difficulty | Hyperactivity | Self-Abusive |
| Anxiety | Memory Loss (st) | Temper | Anti-Social |
| Attention Deficit | Memory Loss (lt) | Dyslexia | Disorientation |

Medical Information

Current Physician: _____ Phone # _____

DOES THE PARTICIPANT HAVE SEIZURES? (please circle) YES No

Date & Type of most recent seizure: _____

DOES THE PARTICIPANT HAVE ANY ALLERGIES? YES No

Please list: _____

Does the participant have a shunt? Yes No Does the participant have bladder or bowel adaptations? Yes No
Type: _____

IS THE PARTICIPANT CURRENTLY ON ANY MEDICATIONS?: (please list) _____

Has the participant undergone any surgical procedures? Please include dates: _____

Below, please circle any conditions that may apply to the participant.

- | | | |
|-------------------------|----------------------|-----------------------------|
| Poor Circulation | Sensory Loss | Autonomic Dysreflexia |
| Cardiovascular Problems | Lack of Stamina | Thermal Regulation Problems |
| Diabetes | Respiratory Problems | |

Snowsports & Recreation Information

Has the participant previously participated in any of these snowsports? (please circle)

Skiing Snowboarding Snowshoeing Cross-Country Skiing Biathlon

Please list any other athletic activities that the participant is involved in: _____

Additional Information: Below, please mention any additional information that will allow us to better serve you and your snow-sports experience.

New England Disabled Sports /DSUSA Membership Information

All participants are required to become members of Disabled Sports USA

Membership Level (please circle) Individual(\$30) Family (\$60)* Donor(\$100)

* Please list family members _____

please make checks payable to "New England Disabled Sports"

Enjoy your time on the snow, please let us know how we can serve you better.

***If possible, please send your registration materials in advance to
New England Disabled Sports -Student Registration, PO Box 26, Lincoln, NH 03251***