



Disabled Sports USA Far West WOUNDED WARRIOR PARTICIPANT INFORMATION



CONTACT INFORMATION:

Name of Participant:			
Date of Birth:			
Group:			
Current Mailing Address:			
City, State, Zip:			
Permanent Address (if different from above):			
City, State, Zip:			
Telephone Numbers	Home:	Cell:	
Email Address:			
Contact Preference	<input type="checkbox"/> e-mail	<input type="checkbox"/> US Mail	<input type="checkbox"/> Do Not Solicit
Height:	Weight:	Hip Width (for wheelchairs users)	
Age:	Gender:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Emergency Contact ↓	Relationship ↓	Home Phone ↓	Cell Phone ↓
1)			
2)			

MILITARY SERVICE INFORMATION:

Status in the U.S. Armed Forces:	<input type="checkbox"/> Active Duty	<input type="checkbox"/> Veteran	<input type="checkbox"/> Reservist
Branch of Service:			
Years of Active Duty:			
Date of Separation from Active Duty:			
Rank:			
Deployment Experience:	<input type="checkbox"/> Operation Iraqi Freedom (OIF)	<input type="checkbox"/> Operation Enduring Freedom (OEF)	



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DISABILITY/MEDICAL INFORMATION:

What is your injury or disability?	
Date of Onset:	
Medications ↓	What are they for?
1)	
2)	
3)	
4)	
Do you have seizures? <input type="checkbox"/> - Yes <input type="checkbox"/> - No	If yes, Date of last seizure Type of seizure
Frequency of seizures:	
Please list any allergies you may have:	
Please describe any body parts susceptible to cold, heat or impact.	
Do you have a cardiac condition? If yes, please describe.	
Do you have a respiratory condition? If yes, please describe.	
Do you experience pain? <input type="checkbox"/> - Yes <input type="checkbox"/> - No	Location of Pain:
Percentage of time you are in pain: On a scale of 1-10, what level of pain are you in?	
Ability to speak: <input type="checkbox"/> - Intact <input type="checkbox"/> - Impaired	
Hearing: <input type="checkbox"/> - Intact <input type="checkbox"/> - Impaired	
Vision: <input type="checkbox"/> - Intact <input type="checkbox"/> - Impaired	
Do you have any diet restrictions? <input type="checkbox"/> - Yes <input type="checkbox"/> - No	Please describe.
Do you have decreased strength in your upper extremities (arms)? <input type="checkbox"/> - Yes <input type="checkbox"/> - No Which side?	
Do you have decreased sensation in either one of your arms/hands? <input type="checkbox"/> - Yes <input type="checkbox"/> - No Which side?	
Will you need any type of adaptation device to hold objects (i.e. paddle, handle bar, etc)?	
Do you have decreased strength in your lower extremities (legs/feet)? <input type="checkbox"/> - Yes <input type="checkbox"/> - No Which side?	
Do you have decreased sensation in either one of your legs/feet? <input type="checkbox"/> - Yes <input type="checkbox"/> - No Which side?	
Do you wear braces?	What type?
Do you have any rods stabilizing any part of your spine?	How long?
Describe any pressure sore or significant bruises?	



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COMBAT STRESS

Do you have panic attacks?	<input type="checkbox"/> - Yes	<input type="checkbox"/> - No
Do you have flashbacks?	<input type="checkbox"/> - Yes	<input type="checkbox"/> - No
Are you sensitive to loud noises?	<input type="checkbox"/> - Yes	<input type="checkbox"/> - No
Do crowds make you feel anxious?	<input type="checkbox"/> - Yes	<input type="checkbox"/> - No
Do you get angry easily?	<input type="checkbox"/> -Yes	<input type="checkbox"/> - No
Are you hyper-vigilant?	<input type="checkbox"/> -Yes	<input type="checkbox"/> - No
Do you isolate yourself?	<input type="checkbox"/> - Yes	<input type="checkbox"/> - No
Do you get anxious easily?	<input type="checkbox"/> - Yes	<input type="checkbox"/> - No
How do you handle stress?		
How can we best support you should you become anxious, fearful, angry, etc?		

AMPUTATION

Status of Injury:	<input type="checkbox"/> - Primary Disability	<input type="checkbox"/> - Secondary Condition
Date of Amputation:	Level of Amputation:	
Please describe your means of mobility (i.e. prosthesis, wheelchair, none, etc.)		
If you have prosthesis, will you be using it while taking part in our program? <input type="checkbox"/> - Yes <input type="checkbox"/> - No		
(Please note: we will not be held responsible if the prosthesis becomes damaged or broken while participating in our programs.)		
Please list ALL safety precautions you take to protect the amputated limb against the cold and falls.		
Please describe what devices/methods you use to prevent skin breakdown or pressure ulcers:		



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MOBILITY

Are you able to walk? <input type="checkbox"/> - Yes <input type="checkbox"/> - No
If yes,
How far of a distance?
What percentage of a day do you walk? <input type="checkbox"/> 25% <input type="checkbox"/> 50% <input type="checkbox"/> 75% <input type="checkbox"/> full-time walking ability
Are you limited by fatigue? Pain? Skin Issues?
What type of terrain are you able to walk on?
<input type="checkbox"/> - flat surface <input type="checkbox"/> - inclines/declines <input type="checkbox"/> - rocky uneven surfaces <input type="checkbox"/> - all
Do you use a mobility device? <input type="checkbox"/> - Yes <input type="checkbox"/> - No
If yes, which device do you use:
<input type="checkbox"/> - Wheelchair <input type="checkbox"/> - Walker <input type="checkbox"/> - Cane <input type="checkbox"/> - Crutches <input type="checkbox"/> - Prosthetic <input type="checkbox"/> - Orthotic <input type="checkbox"/> - Other _____
If using a wheelchair, what percentage of a day do you use with wheelchair?
<input type="checkbox"/> 0% <input type="checkbox"/> 25% <input type="checkbox"/> 50% <input type="checkbox"/> 75% <input type="checkbox"/> full time wheelchair user
Are you able to transfer to/from your wheelchair to:
Multilevel Surfaces? <input type="checkbox"/> - Yes <input type="checkbox"/> - No
Van/Bus/Car? <input type="checkbox"/> - Yes <input type="checkbox"/> - No
Do you need a shower chair? <input type="checkbox"/> -Yes <input type="checkbox"/> - No
Are you independent with your transfers? <input type="checkbox"/> - Yes <input type="checkbox"/> - No
If not, what level of assistance do you need?
<input type="checkbox"/> - minimal (contact guard) <input type="checkbox"/> moderate (pivot transfer) <input type="checkbox"/> - maximum (2 person lift)
Are you independent with your activities of daily living such as bathing, bathroom, dressing, cathing, etc?
<input type="checkbox"/> - Yes <input type="checkbox"/> - No
If no, please explain the assistance you require:



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TRAUMATIC BRAIN INJURY (TBI)

Have you sustained traumatic brain injury?		<input type="checkbox"/> - Yes	<input type="checkbox"/> - No
Status of Injury:		<input type="checkbox"/> Primary Disability	<input type="checkbox"/> Secondary Condition
Date of Injury:			
What is the cause of your TBI?			
Severity of injury?		<input type="checkbox"/> - mild	<input type="checkbox"/> - moderate <input type="checkbox"/> - severe
Has your TBI affected you in any of the following ways?			
Short-term memory impairment	<input type="checkbox"/> - Yes	<input type="checkbox"/> - No	
Decreased attention span	<input type="checkbox"/> - Yes	<input type="checkbox"/> - No	
Problem-solving difficulties	<input type="checkbox"/> - Yes	<input type="checkbox"/> - No	
Inability to concentrate	<input type="checkbox"/> - Yes	<input type="checkbox"/> - No	
Impulsive/Decrease ability to filter what I say and/or do	<input type="checkbox"/> - Yes	<input type="checkbox"/> - No	
Decreased balance	<input type="checkbox"/> - Yes	<input type="checkbox"/> - No	
Vestibular impairment	<input type="checkbox"/> - Yes	<input type="checkbox"/> - No	
Do you get dizzy?	<input type="checkbox"/> - Yes	<input type="checkbox"/> - No	
Do you get motion sickness?	<input type="checkbox"/> - Yes	<input type="checkbox"/> - No	
Do you have difficulty walking?	<input type="checkbox"/> - Yes	<input type="checkbox"/> - No	
Do you have difficulty running?	<input type="checkbox"/> - Yes	<input type="checkbox"/> - No	
Please comment on any characteristics in which you feel we need to know more about.			
Do you have headaches?		<input type="checkbox"/> - Yes	<input type="checkbox"/> - No
How often do they occur?			
What triggers your headaches?			
On a scale of 1 to 10, how severe are your headaches?			



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SKI/SNOWBOARD EXPERIENCE:

Shoe Size (ski/board):		T-shirt Size:	
Skied before?	<input type="checkbox"/> - Yes	<input type="checkbox"/> - No	How many days?
Snowboarded before?	<input type="checkbox"/> - Yes	<input type="checkbox"/> - No	How many days?
Skied/ridden since disability?	<input type="checkbox"/> - Yes	<input type="checkbox"/> - No	How many days?
Last date skied/ridden:			
Type of terrain skied/snowboarded? <input type="checkbox"/> - Green <input type="checkbox"/> - Blue <input type="checkbox"/> - Black <input type="checkbox"/> Bumps			
What equipment do you use? Please check all that apply.			
<input type="checkbox"/> - Alpine	<input type="checkbox"/> - Snowboard	<input type="checkbox"/> - 3 Track (w/ Outriggers)	<input type="checkbox"/> - 4 Track (w/ Outriggers)
<input type="checkbox"/> - Mono-ski	<input type="checkbox"/> - Bi-ski	<input type="checkbox"/> - Snow-slider/Walker	<input type="checkbox"/> - Snow Bike
<input type="checkbox"/> - Blind Bib/Guide Bib	<input type="checkbox"/> - Edgy-Wedgy	<input type="checkbox"/> - Metal Tip Connector	<input type="checkbox"/> - Reins
<input type="checkbox"/> - Don't Know			
Do you have your own equipment? <input type="checkbox"/> - Yes <input type="checkbox"/> - No <input type="checkbox"/> What?			

What other activities do you participate in that have not been mentioned?

Is there any other information you would like us to know?

DISABLED SPORTS USA INSURANCE WAIVER & RELEASE OF LIABILITY and MEDIA RELEASE FORM

DISABLED SPORTS USA INSURANCE WAIVER & RELEASE OF LIABILITY FORM

In consideration of being allowed to participate in any way in Disabled Sports USA and Disabled Sports USA Far West programs, related events, and activities, I and/or the minor participant, for myself, and on behalf of my heirs, assigns, personal representatives and next of kin, the undersigned:

1. Agree that prior to participating, I will inspect, or if a parent and/or legal guardian I will instruct the minor participant to inspect, the facilities and equipment to be used, and if I believe, to the best of my ability, that anything is unsafe, I and/or the minor participant will immediately advise Disabled Sports USA and Disabled Sports USA Far West such condition(s) and refuse to participate.
2. Acknowledge and fully understand that I and/or the minor participant will be engaging in activities that involve risk of serious injury, including permanent disability and death, and severe social and economic losses which might result only from my own actions, inactions or negligence of others, the rules of play, or the condition of the premises or any equipment used. Further, that there may be other risks not known to me or not reasonably foreseeable at this time.
3. Assume all the foregoing risks and accept personal responsibility for the damages following such injury, permanent disability or death.
4. Release, waive, discharge and covenant not to sue Disabled Sports USA, Disabled Sports USA Far West, its affiliated clubs, their representative administrators, directors, agents, coaches, other employees, and volunteers of the organization, other participants, sponsoring agencies, sponsors, advertisers, their heirs, and if applicable, owners and leasers of premises used to conduct the event, all of which are hereinafter referred to as "releasees", from demands, losses or damages on account of injury, including death or damage to property, caused or alleged to be caused in whole or in part by the negligence of the releasee or otherwise.

I/WE HAVE READ THE ABOVE WAIVER AND RELEASE, UNDERSTAND THAT I/WE HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, HAVE NOT CHANGED IT ORALLY, AND SIGN IT VOLUNTARILY.

X _____
Signature Participant's Name (PLEASE PRINT CLEARLY) (MM/DD/YY)

FOR PARTICIPANTS UNDER THE AGE OF 18

This is to certify that I, as parent/guardian with legal responsibility for this participant, do consent and agree to his/her release as provided above of the Releasees, and, for myself, my heirs, assigns, and next of kin, I release and agree to indemnify and hold harmless the Releasees from any and all liabilities incident to my minor child's involvement or participation in these programs as provided above, EVEN IF ARISING FROM THEIR NEGLIGENCE.

X _____
Signature Parent/Legal Guardian Name Relationship Emergency Phone (MM/DD/YY)

MEDIA RELEASE FORM

Name _____ DOB _____ Male ___ Female ___

MEDIA/PHOTO WAIVER: I hereby authorize and give my full consent to Disabled Sports USA (DSUSA) and Disabled Sports USA Far West to copyright and/or publish any and all photographs, digital recordings, videotapes and/or film in which I appear may be used for public view. I further agree that DSUSA and Disabled Sports USA Far West may transfer, use or cause to be used, these digital recordings, photographs, videotapes, or films for any exhibitions, public displays, publications, commercials, art and advertising purposes, television programs, and internet without limitations or reservations.

X _____
Participant Signature (MM/DD/YY)

FOR PARTICIPANTS UNDER THE AGE OF 18

X _____
Signature Parent/Legal Guardian Name Relationship Emergency Phone (MM/DD/YY)