



PARTICIPANT APPLICATION

(Please Print)

**Participation in Maine Adaptive is subject to review and evaluation by Maine Adaptive staff.
If you need assistance completing this application, please call our office & we will assist you: 207-824-2440**

PARTICIPANT INFORMATION

| | | | |
|------------------|-----------------|----------------|-----------|
| Last Name: | First Name: | Today's date: | Gender: |
| | Preferred Name: | Date of Birth: | |
| Mailing address: | City: | State: | ZIP Code: |
| | | | County: |

PHONE NUMBERS:

| | | |
|--------|-------|-------|
| Home: | Work: | Cell: |
| Email: | | |

OCCUPATION HISTORY

| | | |
|------------------------|-----------|--|
| Occupation (optional): | Employer: | Are you a veteran of the US Military? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | Branch of Service: _____ Years Served: _____ to _____ |
| | | Rank at Discharge: _____ |

EMERGENCY CONTACT INFORMATION

| | | | |
|-------------------------|----------------------------|----------------------------|---------------|
| Emergency Contact Name: | Emergency Contact Phone 1: | Emergency Contact Phone 2: | Relationship: |
|-------------------------|----------------------------|----------------------------|---------------|

GUARDIAN INFORMATION

Is the participant their own guardian? No Yes
If NO, please answer the following regarding your guardian:

| | | | |
|--|-------------|---------------|----------|
| Last Name: | First Name: | Relationship: | |
| Check Here if Contact Information is the Same as Participant <input type="checkbox"/> If Not Please fill out contact info below: | | | |
| Address: | City | State | ZIP Code |
| Phone 1: | Phone 2: | Email: | |

MEDICAL INFORMATION

| | | | |
|---|--|---|--|
| Disability/Diagnosis: | Date of Injury (If Applicable): | Briefly describe the nature and/or cause of your disability (for example: auto accident, blood clot, congenital, etc.). | |
| Physician Name: | Physician Phone: | Physician Fax: | |
| Do you have allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list: | | | |
| Do you use an EPI Pen: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, you must bring it to all programming | | | |
| Please answer the following questions about seizures: | Have you ever had a seizure? | Type of Seizure: | Do you take medication for seizures? |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date of last seizure: | <input type="checkbox"/> Yes <input type="checkbox"/> No |

OFFICE USE ONLY

| | | | |
|------------------------|------------------------------|---------------------------|--------------------|
| New Participant? _____ | Date Received ____/____/____ | Entered in Database _____ | revised 10/27/2021 |
|------------------------|------------------------------|---------------------------|--------------------|

Height _____ **ft.** _____ **in.** **Weight:** _____ **lbs**

| | |
|--|--|
| <input type="checkbox"/> Walking <input type="checkbox"/> Partial walking/partial wheelchair <input type="checkbox"/> Wheelchair – Check one: <input type="checkbox"/> MANUAL <input type="checkbox"/> POWER | Please list any mobility aides used in ambulation: |
|--|--|

Please indicate any movement or strength limitations you have. If it is not the same on both sides of your body, use the Left (L) and Right (R) choices to clarify those differences.

| STRENGTH | Weak | | Average | | Strong | | RANGE OF MOTION | Normal | | Limited | |
|---------------------|------|-----|---------|-----|--------|-----|----------------------------|--------|-----|---------|-----|
| | (L) | (R) | (L) | (R) | (L) | (R) | | (L) | (R) | (L) | (R) |
| Upper Body Strength | | | | | | | Upper Body Range of Motion | | | | |
| Lower Body Strength | | | | | | | Lower Body Range of Motion | | | | |

TONE: Do you have normal muscle tone? If NO, how would you describe your tone?

Yes No
 Spastic Athetoid Flaccid Other

| | |
|--|--|
| If you have a visual impairment , please tell us about your vision. Visual Acuity: Field of Vision: Other: | If you have a hearing impairment , please tell us about your hearing: |
|--|--|

| PLEASE CHECK YES OR NO TO THE FOLLOWING QUESTIONS | YES | NO | DETAILS Use the space to below to provide details about anything for which you checked YES. |
|--|-----|----|--|
| Is any part of your body paralyzed? | | | |
| Do you have altered hot/cold sensation? | | | |
| Do you use American Sign Language? | | | |
| Do you have difficulty speaking, communicating, or being understood? | | | |
| Do you have difficulty remembering things? | | | |
| Do you have difficulty following directions? | | | |
| Do you become easily frustrated? | | | |
| Do you ever verbally or physically lose control? | | | |

Do you have any other conditions that might impact your participation with us, for example: fused joints, environmental triggers, cardiac condition?:

PARTICIPATION INFORMATION

Please check the activities in which you are interested in participating.
You will also need to fill out the seasonal sign up form to request specific lesson times

- | | |
|--|---|
| General Program <input type="checkbox"/> Alpine Skiing <input type="checkbox"/> Golf <input type="checkbox"/> Climbing <input type="checkbox"/> Snowboarding <input type="checkbox"/> Paddling <input type="checkbox"/> Hiking <input type="checkbox"/> Snowshoeing <input type="checkbox"/> Tennis <input type="checkbox"/> Pickleball <input type="checkbox"/> Nordic Skiing <input type="checkbox"/> Cycling | Specialty Camps <input type="checkbox"/> Veterans No Boundaries <input type="checkbox"/> Blind & VI Ski Festival <input type="checkbox"/> Mono ski Camp |
|--|---|

| | |
|---|--|
| Do you have experience with the above sports?: | |
| Are you Right or Left Handed?: <input type="checkbox"/> Right <input type="checkbox"/> Left | While wearing a PFD, are you able to turn from face down to face up in the water? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| What other sports or activities do you take part in?: | |
| Do you receive federal or state financial assistance?: <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Have you ever been convicted of a felony (excluding any record that has been judicially sealed, expunged, eradicated or dismissed)? Yes No **If yes, please attach a page of explanation**

The information contained on this application will be used internally by Maine Adaptive staff and volunteer instructors.

| | |
|---|--|
| Please return to: Maine Adaptive Sports & Recreation PO Box 853 Bethel, ME 04217 | Fax: 207-824-0453 Or save a copy & email that to info@maineadaptive.org |
|---|--|