



CHALLENGE ASPEN 2009-10 Winter Season PARTICIPANT INFORMATION SHEET

Please fill out this application completely and accurately and
fax to 970.923.7338 or mail to PO BOX 6639 Snowmass Village, CO 81615

Date: _____

CHALLENGE ASPEN PARTICIPANT

Name: _____

Age: _____ Date of Birth: ____/____/____

Address: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Disability: _____

Disability Details: _____

Height: _____ Weight: _____ lbs.

Hip Measurement: _____ Waist Measurement _____
(Hip and waist for sit-ski only)

Primary Language spoken/understood: _____

Have there been any seizures in the last two years? _____

Is the participant ambulatory? Yes _____ No _____

What are the participant's primary means of mobility (i.e.
power wheelchair, manual wheelchair, cane, walker, etc)?

1. _____
2. _____
3. _____

Local Lodging: _____

Local Phone: _____

PARENT/GUARDIAN INFORMATION

Name: _____

Relation: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email Address: _____

Primary Language Spoken/Understood: _____

EMERGENCY CONTACT INFORMATION (If different from Parent/Guardian)

Name: _____

Relation: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Primary Language Spoken/Understood: _____

CC: VISA MC AMEX CARD# _____

Exp: _____ Vin: _____

PHYSICIAN INFORMATION

Name: _____

Location: _____

Office Phone: _____

Home Phone: _____

Participant's Name: _____

*The following categories pertain to specific disabilities. Please complete the section(s) that most describe the participant's disability and/or any secondary conditions that may exist.
PLEASE ONLY RETURN PAGES THAT APPLY TO THE DISABILITY*

ATTENTION DEFICIT DISORDER

Primary Disability Secondary Condition

ADD ADHD

1. Age at time of diagnosis: _____

2. Please describe the participant's diagnosis: _____

3. Please circle all characteristics that apply to the participant:

Ignores details	Difficulty following directions	Difficulty finishing tasks
Appears forgetful or disorganized	Difficulty staying seated	In constant motion
Excessive talking	Difficulty with quiet activities	Difficulty waiting in line
Often interrupts	Other: _____	

4. Of those circled above, please comment on any characteristics in which you feel we need to know more about. _____

5. Please describe the level of supervision the participant requires. _____

AUTISM

Primary Disability Secondary Condition

Autism (Circle One: Mild Moderate Severe) Aspergers PDD

1. What level of supervision does he/she require? 1:1 all day group supervision only when upset none

2. Please indicate any behaviors he/she may exhibit that staff should be aware of. Please note how you manage each behavior. _____

3. How does the participant communicate with others? (Please circle the MOST appropriate option.)

Speaks in complete sentences	Speaks in single words
Uses effective sign language	Physically takes one to what he/she wants
Uses pictures	Uses a communication board
Speaks in 2-3 word phrases	Uses personal vocalizations or sounds
Uses gestures, points, etc.	Writes or draws needs/wants
Displays word/cue cards	Other: _____

4. What sensory triggers upset him/her? (i.e. sounds, smells, tastes, etc.) _____

5. How do you soothe him/her when he/she is upset? _____

6. Please circle the option that BEST describes the participant's activity levels:

Typical attention span and activity level for child's age
 Very short attention span
 Low activity level; requires motivation to take part in activities
 Overactive
 Easily distracted by sensory stimulation – sights, sounds, people, smells, etc.

Participant's Name: _____

TRAUMATIC BRAIN INJURY

Primary Disability Secondary Condition

1. Please describe the type of head injury (closed, focal, etc.) and its cause. _____

2. Please describe the cause of the injury _____

3. Date of injury? _____

4. Please circle all characteristics that apply to the participant as a result of his/her injury.

- | | | |
|-------------------------------------------|-------------------------------|--------------------------------|
| Joint rigidity | Hemiplegia | Spasticity |
| Non-verbal | Unable to swallow | Poor judgement |
| Difficulty making decisions | Socially inappropriate | Uncooperative |
| Extreme emotional responses | Poor long-term memory | Poor short-term memory |
| Unaware of surroundings | Poor attention span | Difficult thinking abstractly |
| Blurred vision | Double vision | Depressed |
| Angers easily | Disoriented to place and time | Unable to shift activities |
| Unaware of physical/cognitive limitations | Decreased functioning level | Skin breakdown/Pressure ulcers |
| Other: _____ | | |

4. Of those circled above, please comment on any characteristics in which you feel we need to know more about. _____

5. Please describe what devices/methods you use to prevent skin breakdown/pressure ulcers: _____

SPINAL CORD INJURY

Primary Disability Secondary Condition

1. Please indicate the level of the injury (i.e. T-4, C-6, etc.). _____

2. Please describe the cause of the injury _____

2. Date of injury? _____

3. The injury is complete incomplete

4. Please circle all characteristics that apply to the participant as a result of his/her injury.

- | | | |
|-----------------------------------------------------|--------------------------------|-------------------------|
| Paraplegia | Quadriplegia | Loss of bladder control |
| Loss of bowel control | Skin breakdown/pressure ulcers | Blood pressure changes |
| Muscle spasticity | Spinal pain | Autonomic dysreflexia |
| Respiratory distress | Blurred vision | Leg swelling |
| Aspirations | Frequent pneumonia | Contractures |
| Unable to recognize when he/she is too hot/too cold | | Other: _____ |

5. Of those circled above, please comment on any characteristics in which you feel we need to know more about. _____

6. Please describe what devices/methods you use to prevent the following:

- Skin breakdown/pressure ulcers: _____
Preventing him/her from becoming overheated: _____
Preventing him/her from becoming too cold: _____

Participant' Name: _____

AMPUTATION

Primary Disability Secondary Condition

1. Please identify the type of amputation (i.e. above knee, below knee, etc.) _____
2. Please identify the cause of the amputation _____
2. Date of amputation: _____
3. Please describe his/her means of mobility (i.e. prosthesis, wheelchair, none, etc.) _____

4. If he/she has a prosthesis, will he or she be using it while taking part in our program? Yes No
(Please note: we will not be held responsible if the prosthesis becomes damaged or broken while participating in our programs.)
5. Please circle all characteristics that apply to the participant as a result of his/her amputation.
Weight gain Skin breakdown on residual limb(s) Limb pain
Depression Decreased physical activity Muscle loss
Back and/or hip concerns Decrease in bone density Other: _____
6. Of those circled above, please comment on any characteristics in which you feel we need to know more about. _____

7. Please list ALL safety precautions you take to protect the amputated limb against the cold and falls. _____

8. Please describe what devices/methods you use to prevent skin breakdown/pressure ulcers: _____

VISUAL IMPAIRMENT

Primary Disability Secondary Condition

1. Please identify the participant's visual impairment: Partially Sighted/Legally Blind Totally Blind
2. Please circle the reason(s) for the participant's visual impairment:
Cataracts Retinopathy Glaucoma Diabetes
Optic Atrophy Congenital Macular Degeneration Trauma
Retinitis Pigmentosa Other: _____
3. Of those circled above, please comment on any reasons in which you feel we need to know more about. _____

4. How long has he/she had a visual impairment? _____
5. Please describe with detail, the amount of vision the participant has (ie. Light and dark, tunnel, peripheral, etc.) _____

6. Please list any devices used to aid the participant in mobility (i.e. cane, guide, etc.) _____

Participant's Name: _____

HEARING IMPAIRMENT

Primary Disability Secondary Condition

1. Please identify his/her hearing impairment: Partial hearing loss Total hearing loss
2. Please explain the cause of his/her hearing impairment _____

3. How long has the participant had a hearing impairment? _____
4. Does he/she experience ringing in the ears? Yes No
5. Please describe how he/she best communicates with others. _____

DOWN SYNDROME

Primary Disability Secondary Condition

1. Age at time of diagnosis: _____
2. Please circle all characteristics that apply to the participant:
- | | | |
|---------------------|-------------------------------|--------------------------|
| Poor muscle tone | Hyperflexibility | Respiratory difficulties |
| Far sightedness | Near sightedness | Hearing impairment |
| Speech difficulties | Heart defect | Atlantoaxial instability |
| Social implications | Lower resistance to infection | Other: _____ |
3. Of those circled above, please comment on any characteristics in which you feel we need to know more about. _____

4. Please describe the level of supervision he/she requires. _____

WILLIAMS SYNDROME

Primary Disability Secondary Condition

1. Age at time of diagnosis: _____
2. Please circle all characteristics that apply to the participant:
- | | | |
|------------------------|-------------------|---------------------|
| Cardiovascular disease | Joint limitations | Joint laxity |
| Development delays | Cognitive delays | Generalized anxiety |
| ADD/ADHD | Diabetes | Sensitive hearing |
| Non-verbal | Reserved/Shy | Other: _____ |
3. Of those circled above, please comment on any characteristics in which you feel we need to know more about. _____

4. Please describe the level of supervision he/she requires. _____

Participant's Name: _____

SPINA BIFIDA

Primary Disability Secondary Condition

1. Please identify his/her type of Spina Bifida: Meningocele Myelomeningocele

2. Age at time of diagnosis: _____

3. Please circle all characteristics that apply to the participant:

- | | | |
|--------------------------------|-----------------------------------|----------------------------|
| Hydrocephalus | Decreased bladder control | Decreased bowel control |
| Latex allergies | Developmental delays | Cognitive delays |
| Decreased attention span | Difficulty understanding language | Difficulty expressing self |
| Sequencing difficulties | Decreased motor coordination | Seizures |
| Pressure ulcers/Skin breakdown | Speech difficulties | Non-verbal |
| Hearing difficulties | | |
| Other: _____ | | |

4. Of those circled above, please comment on any conditions in which you feel we need to know more about. _____

6. Please describe his/her level of movement and means of mobility. _____

7. Please describe what devices/methods you use to prevent pressure ulcers/skin breakdown. _____

CEREBRAL PALSY

Primary Disability Secondary Condition

1. Please identify his/her type of Cerebral Palsy. Spastic Athetoid Ataxic Mixed

2. Please note the cause of his/her CP. _____

3. Age at time of diagnosis: _____

4. Please circle all characteristics that apply to the participant.

- | | | |
|--------------------------------|-----------------------|-------------------------------------|
| Muscle tightness | Muscle spasms | Involuntary movements |
| Gait and mobility disturbances | Abnormal sensations | Abnormal perceptions |
| Vision impairment | Hearing impairment | Speech impairment |
| Cognitive delays | Feeding difficulties | Decreased bowel and bladder control |
| Respiratory distress | Learning disabilities | Epilepsy |
| Pressure ulcers/Skin breakdown | Latex allergies | Other: _____ |

5. Of those circled above, please comment on any characteristics in which you feel we need to know more about. _____

6. Please describe what devices/methods you use to prevent skin breakdown/pressure ulcers: _____

Participant's Name: _____

DEVELOPMENTAL DELAY

Primary Disability Secondary Condition

1. Please note the cause of the participant's disability. _____

2. Age at time of diagnosis: _____

3. Please describe his/her developmental delay. _____

_____.

4. Please circle all characteristics that apply to the participant.

- | | | |
|----------------------------|------------------------|-----------------------------------|
| IQ 80 or below | Speech delays | Expressive language delays |
| Hearing impairment | Oral motor dysfunction | Impaired visual-spatial abilities |
| Visual impairment | Hyperactivity | Gross motor delays |
| Hypotonia | Social delays | Epilepsy |
| Poor hand eye coordination | Other: _____ | |

5. Of those circled above, please comment on any in which you feel we need to know more about. _____

_____.

LEARNING DISABILITY

Primary Disability Secondary Condition

1. Please note the cause of the participant's disability. _____

2. Age at time of diagnosis: _____

3. Please describe his/her learning disability. _____

_____.

4. Please circle all characteristics that apply to the participant.

- | | | |
|-----------------------------------------------------|----------------------------------|--------------------------------|
| Slow response times | Time concept difficulty | Logic difficulty |
| Sequencing difficulty | Requires increased clarification | Does not consider consequences |
| Difficulty finishing task | Hyperactivity | Oppositional behavior |
| Dyslexia | Poor motor planning | Poor auditory discrimination |
| Writing difficulty | Poor visual perception | Poor memory |
| Poor hand-eye coordination | Easily irritated | Impulsive |
| Unable to make connections between similar concepts | Other: _____ | |

5. Of those circled above, please comment on any in which you feel we need to know more about. _____

_____.

6. What techniques and/or modalities do you use to help the participant learn best? _____

_____.

OTHER

1. Please note the cause of the participant's disability. _____

2. Age at time of diagnosis: _____

3. Please describe his/her disability. _____

_____.

Participant's Name: _____

CURRENT ACTIVITIES

1. Please circle all activities below that relate to the participant's current physical activities. Furthermore, please indicate the frequency and duration of time in which he or she takes part in these activities.

- | | | |
|----------------------|------------------|-----------------|
| Swimming: | Frequency: _____ | Duration: _____ |
| Gymnastics: | Frequency: _____ | Duration: _____ |
| Karate: | Frequency: _____ | Duration: _____ |
| Horseback Riding: | Frequency: _____ | Duration: _____ |
| Hiking: | Frequency: _____ | Duration: _____ |
| Baseball: | Frequency: _____ | Duration: _____ |
| Football: | Frequency: _____ | Duration: _____ |
| Soccer: | Frequency: _____ | Duration: _____ |
| Jogging/Running: | Frequency: _____ | Duration: _____ |
| Rafting: | Frequency: _____ | Duration: _____ |
| Fishing: | Frequency: _____ | Duration: _____ |
| Basketball: | Frequency: _____ | Duration: _____ |
| Skiing/Snowboarding: | Frequency: _____ | Duration: _____ |
| Skateboarding: | Frequency: _____ | Duration: _____ |
| Mountain Biking: | Frequency: _____ | Duration: _____ |
| Theatre/Dance: | Frequency: _____ | Duration: _____ |
| Rollerblading: | Frequency: _____ | Duration: _____ |
| Rock Climbing: | Frequency: _____ | Duration: _____ |
| Other: _____ | Frequency: _____ | Duration: _____ |

2. Please indicate any past **physical** activities in which the participant took part and the reason they are no longer participating:

_____.

3. Please indicate any future **physical** activities in which the participant would like to participate: _____

_____.

4. Please indicate any other activities that he/she participates in and note its frequency and duration (i.e. reading, writing, etc.).

_____.

Participant's Name: _____

GENERAL INFORMATION

1. Please describe the participant socially. (Include age of peers, interests, games and/or activities, etc.) _____

2. Please describe any assistive devices (communication boards, hearing aids, picture cards, motivators, etc.) that the participant may use and the reason for its use. (Note: If appropriate, please allow these assistive devices to accompany your child.) _____

3. Please describe any unique/challenging characteristics that you would like us to consider. _____

4. Please describe any additional strengths (with regard to social skills, physical skills, behavior, communication, etc.) that the participant exhibits. _____

5. Please list three goals you would like to see the participant achieve while participating with Challenge Aspen.

6. Please describe any additional information that will assist us in providing the participant with the best possible experience.

Parent/Guardian Signature: _____

Date: ___/___/___

Parent/Guardian Name (Please Print): _____

Participant's Name: _____

MEDICAL RELEASE

Summer and winter recreational activities with Challenge Aspen are physically oriented and all involve a level of inherent danger. Furthermore, these adaptive activities take place at altitudes of 6,000 feet and above. Prior to taking part in Challenge Aspen programs, we require that each participant have physician's approval in order to ensure the safety of each individual.

The release below must be signed off by the participant's physician before the first day of camp.

PERMISSION TO PARTICIPATE IN CHALLENGE ASPEN PROGRAMS:

Your patient, _____, wishes to take part in an adaptive recreation experience with Challenge Aspen. Are there any medical factors in your patient's history that would affect his or her ability to safely participate in this non-medically supervised program?

YES

NO

If yes, please list and explain: _____

Please identify any recommendations or restrictions that are appropriate for your patient: _____

Is this patient currently taking any medications that will be affected by high altitude activity?

YES

NO

If yes, please list and explain: _____

My patient, _____, has my approval to take part in Challenge Aspen adaptive recreation programs with the restrictions and/or recommendations stated above.

Physician Name: _____

Work Phone: _____

Physician Signature: _____

Date: ____/____/____