2019 CHALLENGE ASPEN EXPEDITION
PARTICIPANT INFORMATION

Please fill out this application completely and accurately. Date: _____

CHALLENGE ASPEN PARTICIPANT

Name: _____

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

Address: _____

_____

_____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Disability: _____

Disability Details:_____

_____

_____

Height:_____ **Weight:** _____

Primary Language spoken/understood:_____

Have there been any seizures in the last two years?

_____Yes _____No

Is the participant able to walk without assistance? __Yes ___No

Is walking the participant's primary means of mobility?

___Yes ___No

If no, please describe the participant's primary means of mobility (i.e. power wheelchair, manual wheelchair, cane, walker, etc.) _____

_____

_____

Does participant have any difficulties with balance while walking?

_____Yes _____No

If yes, please include with participant information.

EMERGENCY CONTACT #1 INFORMATION

Name: _____

Relation: _____

Address: _____

_____

_____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Primary Language spoken/understood: _____

EMERGENCY CONTACT #2 INFORMATION

Name: _____

Relation: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Primary Language spoken/understood: _____

Does the participant have an IEP or behavior plan?

____Yes ____No

If so, please include with participant information.

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*) ☐ Asperger's ☐ 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.	***Please complete additional ChAMP form**

Participant' 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 judgment
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' 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? _____

Participant's Name: _____

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.

Mountaineering:	Frequency: _____	Duration: _____
Hiking:	Frequency: _____	Duration: _____
Jogging/Running:	Frequency: _____	Duration: _____
Skiing/Snowboarding:	Frequency: _____	Duration: _____
Mountain Biking:	Frequency: _____	Duration: _____
Rock Climbing:	Frequency: _____	Duration: _____
Other: _____	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 describe in detail the participant's level of experience participating in sports at high elevation (Above 10,000 feet):

_____
_____
_____

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

_____
_____
_____

5. Have you ever been tent camping? ____Yes ____No
If yes, please provide detail. _____
_____

6. Have you ever traveled internationally? ____Yes ____No
If yes, please provide detail. _____
_____
_____
_____

7. Have you ever participated in a team activity in the outdoors (e.g. hiking or climbing)?
If yes, please provide detail. _____
_____
_____
_____

8. Have you ever been to an elevation of 14,000 feet or higher? ____Yes ____No
If yes, please provide detail. _____
_____
_____
_____

9. Do you have a history of digestive issues when traveling and eating different cultural/trail food? ____Yes ____No
If yes, please provide detail. _____
_____
_____
_____

Participant's Name: _____

MEDICAL INFORMATION

1. Please list ALL medications (prescription and over the counter) the participant currently takes. Please be sure to list medications as accurately and with all information possible. If you need more room, please continue on the back of the page or include a separate sheet.

MEDICATION	DOSAGE & SCHEDULE	REASON	ADDITIONAL INFORMATION

2. Does the participant have a shunt? _____Yes _____No
If yes, please describe all medical procedures, if any, as a result of the shunt. _____

3. Does the participant have any past or current heart conditions? _____Yes _____No
If yes, please provide detail. _____

4. Does the participant have any areas of their body that are susceptible to impact/heat/cold? _____Yes _____No
If yes, please provide detail. _____

5. Has the participant had any recent injuries, surgeries, or skin breakdown in the last year? _____Yes _____No
If yes, please provide detail. _____

6. Does the participant suffer from altitude sickness? _____Yes _____No
If yes, please provide detail. _____

7. Does the participant suffer from motion sickness? _____Yes _____No
If yes, please provide detail. _____

Participant's Name: _____

8. Please list ALL allergies (foods, environmental, medications, etc.) and reactions the participant may have. Please be sure to state how the reactions are controlled.

ALLERGY	REACTION	CONTROL TECHNIQUES/MEDICATIONS

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 achieve while participating in Challenge Aspen's Expedition.

A) _____

B) _____

C) _____

_____

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

_____
_____
_____
_____

Participant (or Guardian) Signature:_____ **Date:**____/____/____

Participant (or Guardian) Name (Please Print): _____

Please fill out this application completely and accurately and return to Challenge Aspen at one of the below:
Mailing: PO Box 6639, Snowmass Village, CO 81615 **Email** jhauser@challengeaspen.org **Fax** 970.923.7338