Special Needs Registration

Participant Information

Name: _____ Parent Name: (if <18) _____

Birthdate: _____ Age: _____

Email Address: _____

Phone Number(s): H: _____ M: _____

Mailing Address: _____

Please describe the participants disability (be specific): _____

Do you use a mobility device? YES ◯ NO ◯

If yes, what kind? _____ How much of the time? _____ %

Height: _____ Weight: _____

Is there a history of seizures? YES ◯ NO ◯ Frequency? _____

Does the participant have any known allergies? YES ◯ NO ◯

If yes, please explain: _____

Is there ***any*** other medical condition or concern that could impact participation? YES ◯ NO ◯

If yes, please explain: _____

Are there any specific modifications or adaptations we can make that will assist us in serving you?

If yes, please describe: _____

Are you currently taking any medications? YES ◯ NO ◯

If yes, please list them: _____

Can the participant independently communicate? YES ◯ NO ◯

If no, please explain: _____

Does the participant utilize a personal aid/e? i.e. interpreter, 1 on 1, tablet etc? YES ◯ NO ◯

If yes, please explain: _____

Behavioral Motivators: _____

Behavioral Triggers: _____

Behavioral Strategies or Suggestions: _____

Have you participated in therapeutic recreation or adaptive sports before? YES ◯ NO ◯

If yes, where and when? _____

What is the primary reason for joining this specific program? i.e. goals, motivations? _____

Programs participant is registering for? _____

_____

By signing below, I confirm that the individual in this form has been diagnosed by a doctor with the aforementioned diagnosis. I additionally understand that a confirmed medical diagnosis is required to participate in this class.

PRINT: _____ SIGN: _____ DATE: _____

All support requests and registration forms are valid for 1 calendar year unless participant has experienced any medical changes. This includes but is not limited to, a change in status or diagnosis, change in medication, undergone surgery or changed assistive device.