# SportsNet Shared Ski Adventures

## Student Application Form

***2019 Ski Season***
***January 12 – March 2***

**Please complete all sections of this Application Form and do not leave any blanks. This form includes a Medical Information section (pages 3 & 4) and it must be signed by your physician.**

***Please print***

**Return form to:** SportsNet / 3399 Winton Road South / Rochester, NY 14623 / Attn: SSA

| **Participant Information:** | | | | | | |
|---|---|---|---|---|---|---|
| *Name:* | | ❑ Male ❑ Female | DOB: | | | |
| *Current Address:* | Street | | | | | |
| | City | | NY | | Zip | |
| *Phone Number:* | | ***Email:*** | | | | |
| *Insurance #:* | | *Ins.Provider:* | | | | |
| *Other Insurance:* | | | | | | |
| **In case of emergency, the following person(s) are to be called:** | | | | | | |
| *Contact 1:* | | *Cell Phone:* | | | | |
| *Relationship:* | ❑ Parent ❑ Guardian ❑ Other: | | | | | |
| *Contact 2:* | | *Cell Phone:* | | | | |
| *Relationship:* | ❑ Parent ❑ Guardian ❑ Other: | | | | | |

| ***Primary* Health Care Provider** | | | | | | |
|---|---|---|---|---|---|---|
| *Policy Holder:* | | *Policy Number:* | | | | |
| *Primary Physician:* | | | | | | |
| *Address:* | Street | | | | | |
| | City | | NY | | Zip | |
| *Phone number:* | | *Fax:* | | | | |
| *Hospital Affiliation:* | | | | | | |

| **Medicaid Service Coordinator Information** (if applicable, please complete) | |
|---|---|
| *MSC Name:* | |
| *Agency Affiliation:* | |
| *Phone Number:* | |

| **Communication** | | | |
|---|---|---|---|
| **Primary Language** | | **Secondary Language** | |
| | English | | English |
| | Spanish | | Spanish |
| | American Sign Language | | American Sign Language |
| | Symbolic / Type = | | Symbolic / Type = |
| | Communication device / Type = | | Communication device / Type = |
| | Non-verbal | | Non-verbal |
| | Other: | | Other: |
| **Comprehension** | | | |
| | Understands verbal directions | | Understands Sign Language |
| | Understands 2-3 step verbal directions | | Uses PECS to communicate best |
| | Understands 1-step verbal directions | | Other: (please describe below) |
| | | | |

| **Self-awareness / Safety** *Parents/Guardians: Please check the situations that participant may need assistance with* | | | |
|---|---|---|---|
| | Wandering away from instructors | | Navigating the parking lot |
| | Being aware of self in relation to others skiers on the hill | | Comprehending the ski hill in terms of staying on the trail |
| | Other: | | |
| Is the participant susceptible to the cold? | ❑ No ❑ Yes | | |
| **How** can participant communicate to an instructor that they feel cold? | | | |
| **How** can participant communicate if something hurts/is painful? | | | |

| **Recreation Interests**<br>***Please take the time to complete this section – it is very helpful info for our instructors!*** | |
|---|---|
| Please list your recreation interests, hobbies or other helpful things for our instructors to know | |
| LIKES (music, books, sports, fave color?, etc) | DISLIKES |
| | |
| | |
| | |
| | |
| | |

## Medical Information

**Health history** *Please check any of the following conditions that you presently have or have had in the past:*

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Diabetes | | Arthritis | | Swelling of hands | | Skin breakdown | | Dizziness |
| | Cancer | | Incontinence | | Swelling of feet | | Latex allergy | | Fainting spells |
| | Chest Pain | | UTIs | | Swelling of ankles | | Latex sensitivity | | Headaches |
| | Heart Disease | | Hernia | | Pneumonia | | Stomach problems | | Head injury |
| | Asthma | | Extreme Fatigue | | Paralysis | | Kidney problems | | Swallowing problems |

**Do you have any of the following directives?**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Do-Not-Resuscitate | | Living will | | Health Care Proxy | | |

## Physical

| | | | |
|---|---|---|---|
| *Primary Diagnosis:* | | *Secondary Diagnosis:* | |
| *Height:* | | *Weight:* | |

Do you walk independently? ❑ Yes ❑ No

**If no**, please indicate what kind of mobility aid is used:

| | | | | | |
|---|---|---|---|---|---|
| | Crutches | | Walker | | Manual wheelchair |
| | Power wheelchair | | Other: | | |

## Vision

Do you wear glasses or corrective lenses? ❑ No ❑ Yes
**If yes**, please describe the degree of visual impairment

## Hearing

Do you use any hearing or communication aids? ❑ No ❑ Yes
**If yes**, please describe degree of hearing impairment:

## Allergies *Please list any known allergies, including medications, food…*

**If you have allergies**, please indicate the type of reaction/symptoms you typically experience:

**Do you carry an EpiPen?** ❑ No ❑ Yes

**Medical restrictions to diet** (diabetic, gluten free, low calorie…)
**there are usually cookies & treats in the Cocoa Hut so this is particularly important for instructors to be aware of!*

## Seizure History

Have you ever had a seizure? ❑ No ❑ Yes **If yes**, please answer the following questions:

Please describe as fully as possible, a typical seizure episode, including physical characteristics, and duration. Describe any warning signs that a seizure is about to occur:

| **Medications** *Please list all current medications* | |
|---|---|
| Medication | Purpose |
| | |
| | |
| | |

| **Does the applicant demonstrate any of the following behaviors?** | | | |
|---|---|---|---|
| **Behavior** | **No** | **Yes** | **If yes, indicate frequency** |
| Physical Aggression | | | ___ Daily ___ Weekly ___ Monthly |
| Wandering/Running Away | | | ___ Daily ___ Weekly ___ Monthly |
| Destroys Property | | | ___ Daily ___ Weekly ___ Monthly |
| Tantrums | | | ___ Daily ___ Weekly ___ Monthly |
| Self Injurious Behavior | | | ___ Daily ___ Weekly ___ Monthly |
| Verbal Outbursts | | | ___ Daily ___ Weekly ___ Monthly |
| Mouthing/Swallowing or eating non-food items | | | ___ Daily ___ Weekly ___ Monthly |
| Interactions with others that are not appropriate | | | ___ Daily ___ Weekly ___ Monthly |
| Other: | | | ___ Daily ___ Weekly ___ Monthly |

**HELMET POLICY**

All SSA students & instructors must wear a helmet for the duration of the program. It must be strapped on and fit correctly. Helmets must be provided by the individual or rented from SWAIN for a fee.

**PERSONAL CARE: A caregiver must be on-site, within visual range of base of the mountain, and available to provide personal care if needed.**

| | | | |
|---|---|---|---|
| Print name of person completing this form: | | | |
| Relationship to Applicant: | | | |
| Signature of person completing this form: | | | |
| **Physician Signature:** | | **Date:** | |

## Participation Preference Form

Once the application is received we will send confirmation of enrollment along with any questions we may have and how many weeks are available depending on instructor and equipment availability.

Although payment is not required for application, payment is required prior to start of season. Participants will not be able to partake in a lesson if payment is not received.

| Please check your preference for the 2017 season and we will do our best to accommodate it. | | | | | |
|---|---|---|---|---|---|
| | **8 lessons - $400.00** | | **4 lessons – 1st 4 weeks - $200.00** | | **4 lesson – 2nd 4 weeks - $200.00** |

**CANCELLATION POLICY**

**Shared Ski Adventures reserves the right to cancel a ski lesson in the event of conditions that would impact the safety of our participants** (for example: not enough snow, high wind advisories, more ice than snow, etc)**. We do not offer refunds for either cancelled or missed days. Skiing is a weather-dependent sport!**

| OFFICE USE ONLY | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | New student | ***Payment*** | Check Amt | | Check #: | | Date Rec'd: | |
| | Returning student | ***Information*** | Credit Amt | | Last 4 #: | | Date to Fin: | |