

**2023 Membership Application & Medical Release
Greek Peak Adaptive Snowsports**

2 ½ hour lesson including equipment for participant with a disability: \$50

Annual Membership for participant with a disability: \$415

Cash or Checks only Please make checks payable to: Greek Peak Adaptive Snowsports (GPAS)

Part 1: Participant Information

Name _____ DOB _____ Years as a member _____

Address _____ City _____ State _____ Zip _____

County of Residence _____ Phone (home) _____ (cell) _____

Email _____

Contact person for emergencies _____ Phone _____

Skiing/Riding Ability ___ New ___ Beginner ___ Novice ___ Intermediate

Disability(ies): *(check all that apply)*

- | | | |
|--|---|---|
| <input type="radio"/> Amputation | <input type="radio"/> Autism | <input type="radio"/> Cerebral Palsy |
| <input type="radio"/> Diabetes | <input type="radio"/> Epilepsy | <input type="radio"/> Hearing Impairment |
| <input type="radio"/> Intellectual Disability (MR) | <input type="radio"/> Learning Disability | <input type="radio"/> Spinal Cord Injury |
| <input type="radio"/> Traumatic Brain Injury (TBI) | <input type="radio"/> Vision Impairment | <input type="radio"/> Other (specify) _____ |

Please list any medications or additional medical conditions:

Please list any additional information that will help our coaches be more effective (i.e. favorites, dislikes, triggers)

Part 2: Participant Certification

If the participant is an adult who is not subject to a guardianship, he or she may sign this application on his or her own behalf. If the participant is a minor under the age of 18, this application must be signed by one of the applicant's parents or a legal guardian. If the applicant is an adult subject to a guardianship, this applicant must be signed by the applicant's legal guardian. The person signing this form must certify one of the following (check whichever box is applicable):

_____ I am an adult eighteen years of age or older and am not subject to any guardianship.

_____ The applicant is a minor under the age of 18 and I am the applicant's parent or legal guardian.

_____ The applicant is an adult over the age of 18 and I am the applicant's legal guardian.

Name of Parent or Legal Guardian: _____

Address of Parent or Legal Guardian: _____

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Part 3: Health History

To be completed by applicant, parent, or legal guardian

- | | | | | | |
|-----------------------|-----------------------|---|-----------------------|-----------------------|--------------------------------------|
| Yes | No | | Yes | No | |
| <input type="radio"/> | <input type="radio"/> | Heart Disease / Heart Defect / High Blood | <input type="radio"/> | <input type="radio"/> | Allergy _____ |
| <input type="radio"/> | <input type="radio"/> | Chest Pain | <input type="radio"/> | <input type="radio"/> | Medicines _____ |
| <input type="radio"/> | <input type="radio"/> | Seizures | <input type="radio"/> | <input type="radio"/> | Insect Stings / Bites _____ |
| <input type="radio"/> | <input type="radio"/> | Diabetes | <input type="radio"/> | <input type="radio"/> | Special Diet |
| <input type="radio"/> | <input type="radio"/> | Concussion / Serious Head Injury | <input type="radio"/> | <input type="radio"/> | Asthma |
| <input type="radio"/> | <input type="radio"/> | Heat Stroke / Exhaustion | <input type="radio"/> | <input type="radio"/> | Tobacco Use |
| <input type="radio"/> | <input type="radio"/> | Blindness / Visual Problem | <input type="radio"/> | <input type="radio"/> | Easy Bleeding |
| <input type="radio"/> | <input type="radio"/> | Contact Lenses / Glasses | <input type="radio"/> | <input type="radio"/> | Emotional / Psychiatric / Behavioral |
| <input type="radio"/> | <input type="radio"/> | Hearing Loss / Hearing Aid | <input type="radio"/> | <input type="radio"/> | Sickle Cell Trait or Disease |
| <input type="radio"/> | <input type="radio"/> | Bone or Joint Problem | <input type="radio"/> | <input type="radio"/> | Immunizations Up to Date |
| | | | <input type="radio"/> | | Other (specify) _____ |

Date of most recent tetanus immunization ____/____/____

If you have Down's syndrome, GPAS requires an x-ray for atlanto-axial instability.

X-ray taken ____ Yes ____ No Results: Positive ____ Negative ____

Signature of Parent/Guardian/Caregiver or Adult Athlete _____ Date _____

Part 4: Medical Release

To be completed by medical provider for participants that DO NOT have a current Medical release form on file with Special Olympics

Blood Pressure ____/____ Weight ____ Height ____

- | | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|--------------|
| Normal | Abnormal | | Normal | Abnormal | |
| <input type="radio"/> | <input type="radio"/> | Vision | <input type="radio"/> | <input type="radio"/> | Skin |
| <input type="radio"/> | <input type="radio"/> | Hearing | <input type="radio"/> | <input type="radio"/> | Neck |
| <input type="radio"/> | <input type="radio"/> | Reflexes | <input type="radio"/> | <input type="radio"/> | Coordination |
| <input type="radio"/> | <input type="radio"/> | Cardiovascular System | <input type="radio"/> | <input type="radio"/> | Extremities |
| <input type="radio"/> | <input type="radio"/> | Respiratory System | | | |

Other _____ Primary MR Etiology/Category (if known): _____

I have reviewed the above health information and have performed an examination on this participant within the past six months and certify that he/she can participate in snowsports activities with Greek Peak Adaptive Snowsports.

Examiner's Signature _____ Date _____

Examiner's Name _____ MD License # _____

Address _____ Phone: _____