2024 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

Bring completed form to the program for your first session. **Make sure Med form is signed by a physician**

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)*

- ◯ Amputation
- ◯ Diabetes
- ◯ Intellectual Disability (MR)
- ◯ Traumatic Brain Injury (TBI)
- ◯ Autism
- ◯ Epilepsy
- ◯ Learning Disability
- ◯ Vision Impairment
- ◯ Cerebral Palsy
- ◯ Hearing Impairment
- ◯ Spinal Cord Injury
- ◯ 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 etc…)

____

____

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	
◯	◯	Heart Disease / Heart Defect / High Blood	◯	◯	Allergy ___________________________
◯	◯	Chest Pain	◯	◯	Medicines ___________________________
◯	◯	Seizures	◯	◯	Insect Stings / Bites________________________
◯	◯	Diabetes	◯	◯	Special Diet
◯	◯	Concussion / Serious Head Injury	◯	◯	Asthma
◯	◯	Heat Stroke / Exhaustion	◯	◯	Tobacco Use
◯	◯	Blindness / Visual Problem	◯	◯	Easy Bleeding
◯	◯	Contact Lenses / Glasses	◯	◯	Emotional / Psychiatric / Behavioral
◯	◯	Hearing Loss / Hearing Aid	◯	◯	Sickle Cell Trait or Disease
◯	◯	Bone or Joint Problem	◯	◯	Immunizations Up to Date
			◯		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	
◯	◯	Vision	◯	◯	Skin
◯	◯	Hearing	◯	◯	Neck
◯	◯	Reflexes	◯	◯	Coordination
◯	◯	Cardiovascular System	◯	◯	Extremities
◯	◯	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:__________________________