COMMON GROUND Outdoor Adventures

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Date Received: / /

Participant Registration Packet and Medical History

This packet must be completed annually. **This form is confidential and is MANDATORY for participation.**

***fields are required for participation**

GROUP/AGENCY/SCHOOL (if applicable):* _____

PARTICIPANT CONTACT INFORMATION

Name* _____ Date of Birth* _____Age* _____
Height:* ____ft __in Weight:* _____ Male: ___Female ____ E-mail Address:_____
Address:* _____ City:*_____
County:_____ State: ___ Zip Code: _____
Phone:* Day/Cell: (____) _____Eve: (____) _____

LEGAL GUARDIAN INFORMATION: Are you your own legal guardian?* _____Yes _____No
If no, please answer the following regarding your legal guardian
Name: _____Relationship: _____
Address: _____ City_____
State: ___ Zip Code: _____ Phone: Day/Cell (____) _____Eve: (____) _____

EMERGENCY CONTACT INFORMATION: (In case of emergency, injury, or illness)
Relative or close friend:* _____Relationship:* _____
Phone:* Day/ Cell (_____)_____ Evening:(_____)_____

Health insurance company:*_____Policy#*_____Physician:* _____

Who should we contact for activity scheduling, if not self?*
Name: _____ Phone:* _____ Relationship:*_____

PARTICIPANT MEDICAL INFORMATON*
Do you have a disability (physical, cognitive, mental, or multiple)?*_____**Yes**_____**No** Please note: our mission is to serve individuals with disabilities. To qualify for most programs you must have a disability.

Diagnosis – Primary*: _____
Secondary: _____
Details*: _____
_____
Date of Onset*:

Have there been any seizures in the last 2 years?* yes___no____
If yes, details of most recent:* _____
Details:* _____
Date of Onset: _____
Are they controlled?_____Yes_____No Details: _____

Allergies, if applicable (food and environmental)*: _____
_____
Details*: _____
_____
Dietary Restrictions:* _____

Medication Information*: Please list all medications the participant is currently taking. Attach additional pages if needed. *Common Ground Staff and Volunteers are not authorized to administer medications. You must bring a care provider if you need assistance in this area.*

_____ No Concerns

Medication	Schedule	Reason	Side Effect

Mobility Needs:

☐ I don't require any aids or assistance

☐ I use a Walker ☐ Cane ☐ Crutches ☐ Braces ☐ Partial walker/partial wheelchair

Wheelchair: ☐ manual ☐ power ☐ Partial Use

Do you need assistance transferring: ☐ Yes ☐ No Describe: _____

Other mobility aids used in ambulation: _____

Please indicate any movement or strength limitations you have. If it is not the same on both sides of your body, use the Left (L) and Right (R) choices to clarify those differences.

STRENGTH	Weak (L)	(R)		Average (L)	(R)		Strong (L)	(R)	Range of Motion	Normal (L)	(R)		Limited (L)	(R)
Upper body									Upper body motion					
Lower Body									Lower body motion					

If you have a **visual impairment**, please tell us about your vision:

If you have a **hearing impairment** please tell us about your hearing:

PLEASE CHECK YES OR NO TO THE FOLLOWING QUESTIONS	**YES**	**NO**	**DETAILS** Use the space below to provide details about anything for which you checked **YES**.
Is any part of your body paralyzed?			
Do you have altered hot/cold sensation?			
Do you use American Sign Language?			
Do you have difficulty speaking or communicating?			
Do others have difficulty understanding you?			
Do you have difficulty remembering things?			
Do you have difficulty following directions?			
Do you become easily frustrated?			
Do you ever verbally or physically lose control?			
Do you need assistance using the restroom?			

Do you have any other medical conditions we should be aware of, for example: fused joints, cardiac condition?

Military Service:
____Active Duty _____Veteran ____Branch ____ Post 2001 ____ Pre 2001

Rate the following items in terms of Difficulty:
(0) No Difficulty (1) Slight Difficulty (2) Moderate Difficulty (3) High Difficulty (4) Extremely Difficult

Ability to Self-Control ___	Speech ___	Range of Motion ___	Balance ___
Decision Making ___	Spatial Orientation ___	General Strength ___	Endurance ___
Concentration ___	Frustration Tolerance___	Muscle Tone ___	Gross Motor ___
Memory ___	Following Directions ___	Upper Body Strength ___	Fine Motor ___
Learning Ability ___	Switching Focus ___	Lower Body Strength ___	Torso Control ___

Any other information you feel would be helpful:

OTHER PARTICPAPTION INFORMATION:

While wearing a pfd (life-jacket), are you able to turn from face down to face up in the water? ☐ YES ☐ NO

Describe your interests? _____

_____

Have you ever been convicted of a felony (excluding any record that has been judicially sealed, expunged, eradicated or dismissed)? ☐ YES ☐ NO **If yes, please attach a page of explanation.**

DEMOGRAPHIC INFORMATION: This information is important for grants. Please complete.
Ethnicity (please circle one)**:** African American Native American Hispanic Caucasian Asian Other: _____
Income Survey:
1. How many families currently reside at your address? (Please only fill out the form for your family)*_____
2. How many persons are in your family?* _____
3. What is the total current combined income of all family members living at this address (including any related, dependent persons over 62 or working children over 18)? Please mark with an "X" or circle the closest number to your income.

Annual income includes the following: Gross amount of wages and salaries before any payroll deductions of all members of the household. The net income from operation of a farm, business or profession. Interest, dividends, social security and pension payments, workers compensation, unemployment, military pay and welfare payments. Income should NOT include food stamps, insurance reimbursements, irregular gifts, or scholarships.

less than $12,850 per year	_____	less than $32,570 per year	_____	less than $44,100 per year	_____
less than $15,930 per year	_____	less than $33,050 per year	_____	less than $48,950 per year	_____
less than $20,090 per year	_____	less than $34,300 per year	_____	less than $52,900 per year	_____
less than $21,450 per year	_____	less than $35,500 per year	_____	less than $56,800 per year	_____
less than $24,250 per year	_____	less than $36,730 per year	_____	less than $60,700 per year	_____
less than $24,500 per year	_____	less than $37,950 per year	_____	less than $64,650 per year	_____
less than $27,550 per year	_____	less than $39,200 per year	_____	more than $64,650 per year	_____
less than $28,410 per year	_____	less than $40,400 per year	_____		