Hospital for Special Care

ADAPTIVE SPORTS PROGRAMS

Participant Registration Form

Program(s): *(Check all that apply)*

- ☐ Chargers Wheelchair Soccer Team
- ☐ Cruisers Track & Field and Racing Team
- ☐ Hospital for Special Care Ivan Lendl Adaptive Sports Camp
- ☐ Hospital for Special Care Life Skills Mentorship Program
- ☐ Spokebenders Wheelchair Basketball Team
- ☐ Sports & Recreation Clinic
- ☐ Wave Swim Team

Role(s): *(Check all that apply)*

- ☐ Athlete
- ☐ Coach
- ☐ Volunteer
- ☐ Student Observer
- ☐ Professional
- ☐ Other: _____

APPLICANT INFORMATION

_____
Name of participant – last, first, middle

Date of birth: ___/___/___ Age: _____ Height: _____ Weight: _____ Gender: □ M □ F

_____
Home address Number and street City/State/Zip

(_____) _____ (_____) _____ _____
Home phone Cell phone Email address

T-shirt size: ____ Youth S ____Youth M _____ Youth L ____Adult S _____Adult M _____Adult L _____Adult XL

PARENT INFORMATION

_____(_____)_____(_____)_____
Mother/legal guardian name Cell phone Other

_____(_____)_____(_____)_____
Father/legal guardian name Cell phone Other

EMERGENCY CONTACT *(other than parent/guardian)*

_____(_____)_____
Name Phone Relationship to applicant

HEALTH HISTORY

Primary diagnosis _____ Date of onset: _____
Secondary diagnosis _____ Date of onset: _____

Please check and provide an explanation for any present or past conditions that apply below:

☐ Allergies	☐ Communication	☐ Health	☐ Seizures	☐ Vision
☐ Behavioral	☐ Digestion	☐ Hearing	☐ Sensation	☐ Other *(please list below)*
☐ Bone/joint	☐ Elimination	☐ Heart	☐ Special diet	
☐ Breathing	☐ Emotional/ mental	☐ Muscular	☐ Thinking/ cognition	
☐ Circulation		☐ Pain		

Explanation:

_____
_____

Date of last tetanus shot/booster: _____

SIGNIFICANT MEDICAL PROCEDURES *(Describe procedure and date)*

_____
_____

MEDICATIONS *(Include name, dose, frequency for all prescriptions, emergency and over-the counter medications)*

_____
_____

ADVERSE REACTIONS *(Please list any adverse reactions to medications or environmental stimuli that could affect individual's participation)*

_____
_____

DESCRIBE YOUR ABILITIES/DIFFICULTIES IN THE FOLLOWING AREAS (*include assistance required or equipment needed)*

PHYSICAL FUNCTION *(i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)*

_____
_____

ACTIVITY RESTRICTIONS

_____
_____

PSYCHO/SOCIAL FUNCTION *(i.e. Work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.)*

_____
_____

TOILETING

Urinary: ☐ Continent ☐ Incontinent Bowel: ☐ Continent ☐ Incontinent
Assistance required by applicant/devices used: _____
If assistance required, explain toileting regimen including degree of assistance needed, transfer ability/needs and who manages toilet needs at home.

GENERAL INFORMATION

Has applicant participated in Hospital for Special Care programs before? ☐ Yes ☐ No

How did you hear of Hospital for Special Care Adaptive Sports /Mentorship Programs? *(Check all that apply)*

☐ Web site ☐ Newspaper ☐ Friend ☐ Brochure ☐ Therapy clinic ☐ School ☐ Physician office

☐ Other: _____

Which category best describes applicant's race or ethnicity?

☐ African American (not of Hispanic origin) ☐ Asian American or Pacific Islander

☐ Caucasian/White (not of Hispanic origin) ☐ Hispanic ☐ multiracial

Does applicant participate in adaptive sports or mentorship programs outside of Hospital for Special Care programs?

☐ Yes ☐ No If yes, what programs: _____

What are your strengths? _____

Is there a special goal this year you would like to achieve while participating? _____

_____

Do you have any concerns about participating? _____

_____

Primary care physician name: _____ Phone: _____

Insurance company name: _____

Policy number: _____ Policy holder's name: _____

Please return completed registration form to:

Janet Connolly, MS, CTRS, Sports & Community Program Manager
Hospital for Special Care Adaptive Sports
2150 Corbin Avenue
New Britain, Connecticut 06053
Email: jconnolly@hfsc.org Fax: 860-612-6368 Phone: 860-832-6220

FOR OFFICE USE ONLY

Date rec'vd: _____

Additional Forms	Date Sent	Date Rec'vd	Update
Aquatic Rehab Center Registration	_____	_____	_____
HSC Confidentiality Agreement	_____	_____	_____
HSC Liability Waiver	_____	_____	_____
HSC Mentorship Liability Waiver	_____	_____	_____
HSC Photo Release	_____	_____	_____
HSC Ivan Lendl Camp Medical Form	_____	_____	_____
HSC Ivan Lendl Camp Waiver/Photo Release	_____	_____	_____
HSC Ivan Lendl Camp Medical Authorization	_____	_____	_____
HSC Ivan Lendl Camp Prescription Authorization	_____	_____	_____