

Outdoor Adventures Program Application 2013



Please Check All That Apply:

- Participant
- Care Provider
- Family Member
- Friend

Name _____

Address _____ Apt# _____

City _____ State _____ Zip _____

Home # _____ E-mail _____

Work # _____ Work Extension _____

Fax # _____ Cell/Pager # _____

Have you ever received services at Casa Colina? _____ If Yes, Date: _____ Dept: _____

The Outdoor Adventures program exists to serve persons with disability. In order to best serve you, the program participants, please be as detailed as possible regarding your disability. Please answer all questions thoroughly including any special health care needs you may require.

Date Of Birth _____ Height _____ Weight _____ Male Female

Your Disability _____ Date Of Onset _____

Do Any Of The Following Apply To You?

- | | |
|--|--|
| <input type="checkbox"/> Wheelchair-Manual | <input type="checkbox"/> Crutches |
| <input type="checkbox"/> Wheelchair-Power or Scooter | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Cane | <input type="checkbox"/> Service Dog |
| Can you walk unassisted on uneven terrain? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you use a catheter? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you use a diaper? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you utilize the services of an attendant when: | |
| Eating | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bathing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Toileting | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dressing | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Comfortable In The Water | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Swimmer <input type="checkbox"/> or Non Swimmer <input type="checkbox"/> | |
| 1. Have you had <i>any</i> seizures in the last year? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If "Yes", when: _____ | |

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adventure@casacolina.org

2. Date of last tetanus shot: _____
3. Are you currently under the care of any medical specialist or doctor? Yes No
 If "yes" please provide more information : _____
4. Do you have any food allergies or dietary restrictions? Yes No
5. Are you currently taking *any* medications? Yes No

Have you or are you experiencing any of the following? Please check all that apply.

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies To Medications | <input type="checkbox"/> Dysreflexia | <input type="checkbox"/> Knee/Joint Conditions |
| <input type="checkbox"/> Allergies-Other | <input type="checkbox"/> Ear Drum Perforation | <input type="checkbox"/> Lung/Reparatory Issues |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Behavioral Issues | <input type="checkbox"/> Fainting/Blackouts | <input type="checkbox"/> Pressure Sores |
| <input type="checkbox"/> Bowel/Urinary Issues | <input type="checkbox"/> Headaches | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Communicable Disease | <input type="checkbox"/> Heart Defect/Disease | <input type="checkbox"/> Spinal Conditions |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Stones/Infection | <input type="checkbox"/> Visual Impairment |

If you answered "Yes" to any of the questions above, please elaborate on a separate sheet of paper. If you answered "Yes" to question #5 above, please complete the "Trip Medications Sheet".

Please complete ALL information accurately as it is necessary for us to have should you require medical care.

Health Insurance Company _____	Policy Number _____
Personal Physician _____	Physician's # _____
Emergency Contact Name _____	Relationship _____
Home # _____	Alternate # _____

If the participant is under 18 years of age, or is unable to sign due to other incapacity, the signature of a parent, spouse or legal guardian is required.

Consent For Treatment

IN CASE OF EMERGENCY, the UNDERSIGNED authorizes Casa Colina staff and personnel to provide such medical assistance as they determine to be necessary. The UNDERSIGNED authorizes any licensed physician and/or medical facility to provide any medical/surgical care and/or hospitalization for the participant, including anesthetics, which they determine necessary or advisable, pending receipt of a specific consent from the UNDERSIGNED. The UNDERSIGNED authorizes necessary care by paramedics.

Date: _____ Signed: _____

Signature of parent, spouse or legal guardian: _____

Media/Photo Release

I hereby authorize Casa Colina to photograph and/or interview me and to use the photographs and/or interviews for educational, scientific, charitable, public relations and/or commercial goals, such as human-interest stories, advertisements, promotions, exhibitions, publications etc., at the discretion of the corporation and without limitations or reservations. The term "photograph" includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.

Date: _____ Signed: _____

Signature of parent, spouse or legal guardian: _____