Outdoor Adventures & Wheelchair Sports Program Application 2025

Please Check All That Apply:

- ❒ Participant/Participant's Legal Representative
- ❒ Care Provider
- ❒ Family Member
- ❒ Friend
- ❒ Domestic Partner

Name _____

Address _____ Apt# _____

City _____ State _____ Zip _____

Home # _____ E-mail _____

Fax # _____ Cell # _____

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 participant, 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 _____ Age ____ Height _____ Weight _____ ❒ Male ❒ Female ❒ Non-Binary

Your Disability: _____ **Lesion Level:** _____ **Date Of Onset**: _____

Please check the box for any of the following that apply to you:

❒ Wheelchair-Manual		❒ Crutches		
❒ Wheelchair-Power or Scooter		❒ Walker		
❒ Cane		❒ Service Dog		
Can you walk unassisted on uneven terrain?	❒	Yes	❒	No
Do you use a catheter?	❒	Yes	❒	No
Do you use a diaper?	❒	Yes	❒	No
Do you utilize the services of an attendant when:				
Eating	❒	Yes	❒	No
Bathing	❒	Yes	❒	No
Toileting	❒	Yes	❒	No
Dressing	❒	Yes	❒	No
Comfortable in the Water	❒	Yes	❒	No
Are you a swimmer	❒	Yes	❒	No
1. Have you had *any* seizures in the last year?	❒	Yes	❒	No

If "Yes", when and type of seizure?_____

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
   If "Yes", please complete the "Trip Medications Sheet".
6. Do you have any dietary restrictions or food allergies? ☐ Yes ☐ No
7. Are you allergic to latex? ☐ Yes ☐ No

If you answered "Yes" to any of the questions above, please elaborate on a separate sheet of paper.

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

☐ Allergies To Medications	☐ Diabetes	☐ Kidney Stones/Infection
☐ Allergies-Other	☐ Dysreflexia	☐ Knee/Joint Conditions
☐ Arthritis	☐ Ear Drum Perforation	☐ Lung/Respiratory Issues
☐ Behavioral Issues	☐ Ear Infections	☐ Mental Illness
☐ Blood Pressure Issues	☐ Fainting/Blackouts	☐ Pressure Sores
☐ Bowel/Urinary Issues	☐ Headaches	☐ Seizures
☐ Chemical Dependency	☐ Hearing Impairment	☐ Spinal Conditions
☐ Communicable Disease	☐ Heart Defect/Disease	☐ Visual Impairment

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 unable to sign due to other incapacity, the signature of a parent, spouse or legal representative 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 representative: _____