####  *Outdoor Adventures*

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# *Program Application 2018*

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 Age Height Weight ❒ Male ❒ Female

**Your Disability**  **Date Of Onset**

Do Any Of The Following Apply To You?

* Wheelchair-Manual
* Wheelchair-Power or Scooter
* Cane
* Crutches
* Walker
* 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

Swimmer ❒ **or** Non Swimmer ❒

1. Have you had *any* seizures in the last year? ❒ Yes ❒ No

If “Yes”, when:

1. Date of last tetanus shot:
2. Are you currently under the care of any medical

specialist or doctor? ❒ Yes ❒ No

­If “yes” please provide more information­­­­­­ : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have any food allergies or dietary restrictions? ❒ Yes ❒ No
2. Are you currently taking *any* medications? ❒ Yes ❒ No

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

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