



Outdoor Adventures & Wheelchair Sports Program Application 2026

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:

- | | | | |
|---|--------------------------------------|-----------------------------|--|
| <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 | |
| Are you a swimmer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| 1. Have you had <i>any</i> seizures in the last year? | <input type="checkbox"/> Yes | <input type="checkbox"/> 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:

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