(Office use only)
Date: ____/____/____ **Initials:**
❑ New Member
❑ Updated Profile

GAYLORD SPORTS ASSOCIATION MEMBER PROFILE

Please print legibly. Please use other side or additional paper as needed.

CONTACT INFORMATION

First Name:______________________Last Name:____________________Date:___________________

Address:____

City:______________________State:_______Zip Code:________________

PHONES: Mobile:_______________Home:________________Work:_____________________

Email Address:____

Emergency Contact:__________________________Relationship:____________Phone:______________

Primary Physician:_____________________Phone:____________________

Date of Birth:____/____/____ Age:____ ❑ Male ❑ Female Height:___'____" Weight:______lbs Shirt Size:_____

Are you your own legal guardian? ❑ Yes ❑ No

If the answer is NO, your legal guardian or legal representative must sign the waiver and release of liability agreement on your behalf. Please provide the following information about your guardian.

First Name:______________________Last Name:____________________Relationship:_________________

Name of person completing this form:______________________________Relationship:___________________

MILITARY INFORMATION

Are you a Veteran? ❑ Yes ❑ No

If Yes: Service Branch:___________________Rank:________________

❑ Vet/No War ❑ Korea ❑ Vietnam ❑ Gulf ❑ Iraq ❑ Afghanistan

Are you currently: ❑ Active Military Duty ❑ Reserve ❑ Veteran ❑ OEF/OIF

Where were you stationed? What division?:____

Please tell us of any Miltary Awards Conferred:____

Do you have a military disability classification? ❑ Yes ❑ No If YES, what % Disabled?:_____________

Are you currently recieving INPATIENT care at a medical facility? ❑ Yes ❑ No **If YES, MD note required***

Which VA Medical Center do you utilize for your care?:___________________________________

BACKGROUND INFORMATION & INTERESTS

How did you hear about the Sports Association?:____

What are your adaptive sport goals?:____

Have you been a Gaylord inpatient or outpatient? ❑ Yes ❑ No If YES, please specify:__________________________

Have you participated in a Sports Association Event in the past? ❑ Yes ❑ No

Are you currently working? ❑ / attending school? ❑ / volunteering? ❑ (check which applies)

Do you have a service dog? ❑ Yes ❑ No Will you bring the dog to this event? ❑ Yes ❑ No (No family pets please)

I am interested in these sports offered by the Sports Association:

❑ Archery	❑ Golf	❑ Sled Hockey
❑ Boccia	❑ Kayaking	❑ Wheelchair Tennis
❑ Wheelchair Curling	❑ Wheelchair Rugby	❑ Triathlon
❑ Cycling	❑ Rock Climbing	❑ Water Skiing
❑ Fishing	❑ Skiing, Downhill	❑ Yoga

Other Sports of Interest:

❑ Indoor Cycle Training	❑ Horseback Riding	❑ Wheelchair Basketball
❑ Sailing	❑ Swimming	❑ Rowing
❑ Seated Fencing	❑ Road Racing/Running	❑ Other:____________________
❑ Fitness/Strength Classes	❑ Target Shooting	
❑ Scuba Diving	❑ Cross Countr Skiing	

Do you have intermediate or advanced level skills in any of the above sports (pre-injury or post-injury)? ❑ Yes ❑ No

If so, please describe:____

I have participated in water based activities within the past year? ❑ Yes ❑ No (Please note, participants must meet essential eligibility requirements for water sports. Please contact us for details).

PRIMARY DIAGNOSIS

Date of Injury or Onset:_____/_____/_____

❑ Spinal Cord Injury: Level:__________

❑ Complete ❑ Incomplete

❑ Traumatic Brain Injury

❑ Multiple Sclerosis

❑ CVA/Stroke

❑ PTSD

❑ Acquired Brain Injury: Please specifiy:

____

❑ Amputee:

❑ Leg: ❑ Right ❑ Left

❑ Above Knee ❑ Below Knee

❑ Arm: ❑ Right ❑ Left

❑ Above Elbow ❑ Below Elbow

❑ Other Diagnosis: (orthopedics, neurological, spina bifida, cerebral palsy): Please provide details:

____

MEDICAL HISTORY

Please check if you have history of any of the below items:

- ❑ Anxiety / Panic Disorders
- ❑ Readjustment issues since injury
- ❑ Chronic pain requiring narcotics
- ❑ Drug / Alcohol Use
- ❑ Asthma
- ❑ Prescribed blood thinners such as Coumadin
- ❑ Cardiac Condition (Coronary Heart Disease, Myocardial infarction)
- ❑ Heat Stroke
- ❑ Cancer
- ❑ Pressure Ulcers
- ❑ Acute Tuberculosis
- ❑ COPD / Pulmonary Disease
- ❑ Hepatitis
- ❑ Skin Infections
- ❑ Surgical Procedures: Date(s):__________________Type:___________________
- ❑ Autonomic Dysreflexia If yes, How frequently? / Last occurrence:_______________
- ❑ Diabetes Type:________
- ❑ Spinal Surgery Date:____/____/____
- ❑ Hospitalization within past year. If yes, Date and Reason:_____________________________
- ❑ Have you ever had seizures? Date of last seizure: ____/____/____

  Type of seizure (Focal, Grand Mal, Petite Mal):_____________How frequently?:_____________

MEDICAL INFORMATION

Do you have any ALLERGIES? ❑ Yes ❑ No Please List:____

Do you have any DIETARY REQUIREMENTS? ❑ Yes ❑ No Please Describe:________________________________

Do you SMOKE? ❑ Yes ❑ No (Please note that Sports Association complies with Gaylord Hospital's No Smoking Policy)

Are you currently taking any MEDICATIONS? ❑ Yes ❑ No If YES, please list and indicate any pertinent side effects (please attached list if you need additional space):____

____

Do you currently have any open wounds? ❑ Yes ❑ No If YES, stage / condition:______________________________

Do you have any BLADDER or BOWEL ADAPTATIONS (such as catheter or leg bag)? ❑ Yes ❑ No Please List:____

____

Do you require an attendant (to assist you)? ❑ Yes ❑ No If YES, will you bring someone to assist you?___________

(We are not able to provide assistance with personal care needs)

Are you able to obtain a doctor's note for participation in adaptive sports? ❑ Yes ❑ No (A doctor's note may be required based on medical history or requirements for participation in a specific sport.)

PHYSICAL FUNCTIONING

Do you use a wheelchair for mobility? ❑ Yes ❑ No If YES, what type (manual, power)?___________________

Do you require assistance for wheelchair mobility?____

Do you use an assistive device(s) for mobility? ❑ Yes ❑ No If YES, what type (cane, walker)?_______________

Do you use other adaptive equipment for mobility? If YES, please specify:______________________________

Do you require assistance to transfer yourself from one surface to another, such as into a vehicle or onto the floor?

❑ Yes ❑ No If YES, please describe:____

Do you have any difficutly breathing? ❑ Yes ❑ No

Do you need to limit your activities for any reason? ❑ Yes ❑ No Please describe:_______________________

Do you participate in any exercise program? ❑ Yes ❑ No Please describe:____________________________

Do you have LIMITED RANGE OF MOTION? ❑ Yes ❑ No Please indicate location and describe:_____________

____

How would you describe your endurance: ❑ Excellent ❑ Good ❑ Fair ❑ Limited

Do you have impaired strength, muscle tone, spasticity or paralysis? ❑ Yes ❑ No If YES, indicate affected area and describe:____

Do you have difficutly with balance? ❑ Yes ❑ No Describe:____

Do you have any difficulties feeling hot and cold normally? ❑ Yes ❑ No If YES, describe:__________________

VISION & HEARING

Do you wear glasses? ❑ Yes ❑ No Do you wear contact lenses? ❑ Yes ❑ No

Please mark any of the following that are true about your vision:

❑ Legally Blind (best corrected <20/200ou) ❑ Totally Blind ❑ Double Vision

❑ Visual Field Loss: Please describe:____

❑ Other Visual Problems (Preceptual, Depth, Neglect, etc.) Please describe:___________________________

Do you have a hearing impairment? ❑ Yes ❑ No Please explain:____________________________________

If YES, please specifiy: ❑ Left ear affected ❑ Right ear affected ❑ Both ears affected

Do you use a hearing aid? ❑ Yes ❑ No

COMMUNICATION

Do you have difficulty making needs known to instructor? ❑ Yes ❑ No

Do you have difficulty speaking or communicating? ❑ Yes ❑ No

Do others have difficulty understanding you? ❑ Yes ❑ No

Do you have difficulty remembering things? ❑ Yes ❑ No

Do you have difficulty in learning new things? ❑ Yes ❑ No

Do you have difficulty following directions? ❑ Yes ❑ No

If YES to any of these questions, PLEASE EXPLAIN:____

Do you use non-verbal communications? ❑ Yes ❑ No If YES, which type:_________________________________

BEHAVIOR / EMOTIONS

Are you ever impulsive? ❑ Yes ❑ No

Do you become easily frustrated? ❑ Yes ❑ No

Do you become angry easily? ❑ Yes ❑ No

Do you ever physically or verbally lose control? ❑ Yes ❑ No If YES, please describe in detail:____________________

____

Do you know of any reason you should not participate in any of these adaptive sports or special events?

❑ Yes ❑ No If YES, please explain here:____

PLEASE PROVIDE ANY ADDITIONAL INFORMATION THAT MAY HELP US TO PREPARE FOR A SUCCESSFUL ADAPTIVE SPORTS EXPERIENCE:____

____

ACKNOWLEDGEMENT

By signing below, I verify that the above information is current and accurate. I understand that the above information will be kept confidential. In order to provide a safe and fun experience your information may be shared with: (1) Sports Association staff, coaches or instructors (2) other adaptive sports programs who will be working with you (3) medical professionals in case of emergency (4) as required for Sports Association grant reports. I understand that it is my responsibility to inform the Sports Association regarding changes to my: (1) contact information such as address, phone and email; (2) medical status including new diagnosis, surgery or medical changes; (3) any other information that is relevant to the safety of myself or others regarding my participation in Sports Association programs.

Printed Name of Participant or Legal Guardian:____

Signature of Participant or Legal Guardian:_____________________________________Date:____/____/____

Please Mail, Fax or Email completed member profile to:

Gaylord Hospital, Sports Association, PO Box 400, Wallingford, CT 06492, sports@gaylord.org
FAX: 203-284-2813 Attn: Sports Association, PHONE: 203-284-2772