



## ADDS MEMBERSHIP APPLICATION: CONFIDENTIAL MEDICAL QUESTIONNAIRE

Name: \_\_\_\_\_ OHIP #: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Tel #: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 (mm/dd/yyyy)

Person(s) to call in case of emergency:  
 Name: \_\_\_\_\_ Tel #: \_\_\_\_\_  
 Name: \_\_\_\_\_ Tel #: \_\_\_\_\_  
 Family Doctor: \_\_\_\_\_ Tel #: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

### I. MEDICAL INFORMATION:

Mark all medical conditions that apply to applicant with an "X", and add details as indicated:

- Amputations:
  - Hand                    Left                    Right
  - Arm                       Left                    Right                    Below Elbow    Above Elbow
  - Leg                       Left                    Right                    Below Knee      Above Knee
  - Ski with Prosthesis                    Ski without Prosthesis

- Closed head injury
- Hemi-paresis/paralysis    Arm    Leg    Trunk  Left    Right
- Paraplegia / Quadriplegia: Level of Lesion: \_\_\_\_\_
- Sensory Loss:    Touch    Pain    Hot    Cold    Kinesthetic
- Location: \_\_\_\_\_
- Seizure Disorder: Frequency: \_\_\_\_\_ Seizure precipitant(s): \_\_\_\_\_
- Visual Deficit/Description: \_\_\_\_\_
- Fragile Bones
- Bruise Easily
- Cardiac Problem – Describe: \_\_\_\_\_
- Diabetes
- High Blood Pressure                    Low Blood Pressure
- Sensory-motor Problem - Describe: \_\_\_\_\_
- Cerebral Palsy-- Describe motor problems: \_\_\_\_\_
- Inco-ordination of                    Arms Legs    Trunk
- Impaired mobility—Mobility Aids Used:    Cane(s)    Crutches    Walker
- Wheelchair    Scooter    Other: \_\_\_\_\_
- Cognitive / Communication Problem—Describe: \_\_\_\_\_
- Other Disabilities / medical conditions - Describe: \_\_\_\_\_

**ADDS' Applicant's Name:** \_\_\_\_\_

**Medication:** List of all medications taken and possible side effects to watch for:

Medications:

Side Effects:

<u>Medications:</u>	<u>Side Effects:</u>

**II. ACTIVITIES OF DAILY LIVING:**

Mark all functional problems that apply to applicant with an "X", and add details as indicated:

- Dressing: Need help with: \_\_\_\_\_
- Toileting: Need help with: \_\_\_\_\_
- Feeding self: Need help with: \_\_\_\_\_
- Topographical Orientation: Need help with: \_\_\_\_\_
- Other: \_\_\_\_\_

**III. COGNITIVE, BEHAVIOURAL, AND PSYCHO-SOCIAL SKILLS:**

Mark all functional problems that apply to applicant with an "X", and add details as indicated:

- Ability to communicate needs
- Sexual disinhibition / inappropriate behavior: \_\_\_\_\_
- Anger control problem
- Aggression
- Short-term Memory problem
- Taking / Borrowing without asking
- Requires supervision/direction/companion when not skiing
- Other: \_\_\_\_\_

**IV. FOR ALL NEW MEMBERS AND/OR AS REQUESTED BY ADDS' DIRECTORS:**

1. To be completed by the applicant's Health Practitioner:

I certify that \_\_\_\_\_, born \_\_\_\_\_, is medically fit to participate in the sport of disabled skiing, as per the below:

- Without extraordinary precautions
- With precautions: \_\_\_\_\_

Health Practitioner's Name/address (print clearly): \_\_\_\_\_

Credentials: \_\_\_\_\_ Tel #: \_\_\_\_\_

Health Practitioner's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

2. **Skier Assessment** – to be completed by an ADDS-associated occupational or physio therapist, or other approved health practitioner, prior to acceptance of application. This assessment is only to determine strengths and weaknesses to assist in determining ski equipment and support needs and ADDS' ability to meet these needs. It does not replace a medical release and does not guarantee acceptance into ADDS.

I certify that the above information is correct.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please Return to "ADDS Membership" c/o Brad Ko, a minimum of 1 week before your first planned ski day:**

Via Email to: [brad.ko@gmail.com](mailto:brad.ko@gmail.com)