AADS PARTICIPANT APPLICATION
Confidential Medical Questionnaire

Applicant Information		
Applicant's Name: _____	**Date of Birth:** _____	**OHIP Number:** _____
Phone: _____	**Email:** _____	
Street Address (Apartment, suite, unit, etc.): _____		
City: _____	**Postal Code:** _____	
Person(s) to Call in Case of Emergency		
Emergency Contact 1: _____	**Relationship:** _____	
Phone: _____	**Alternate Phone:** _____	
Emergency Contact 2: _____	**Relationship:** _____	
Phone: _____	**Alternate Phone:** _____	
Family Doctor Information		
Family Doctor's Name: _____	**Phone:** _____	
Family Doctor's Full Address: _____		

I. Medical Information

Mark all medical conditions that apply to the applicant with an "X" and add details where 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: _____

AADS' Applicant's Name: _____

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

Medications	Possible Side Effects

II. Activities of Daily Living

Mark all functional problems that apply to the applicant with an "X" and add details where indicated.

☐ Dressing: Need help with: _____

☐ Toileting: Need help with: _____

☐ Feeding self: Need help with: _____

☐ Topographical Orientation: Need help with: _____

☐ Other: _____

III. Cognitive, Behavioral, and Psycho-Social Skills

Mark all functional problems that apply to the applicant with an "X" and add details where 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 AADS' Directors

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

I certify that _____, born_____, is medically fit to participate in the sport of adaptive skiing or adaptive snowboarding, as per the below:

☐ Without extraordinary precautions

☐ With precautions: _____

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

_____

Credentials: _____ Tel #: _____

Health Practitioner's Signature: _____ Date: _____

2. **Participant Assessment** – to be completed by an AADS-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 AADS' ability to meet these needs. It does not replace a medical release and does not guarantee acceptance into AADS.

I certify that the above information is correct.

Print Name: _____

Signature: _____ Date: _____

Submission Instructions

The completed and signed form must be received at least seven (7) days before the Applicant's first planned ski day.

Submit it to: AADS Membership, c/o Brad Ko, 3 Copland Trail, Aurora, Ontario L4G 4S9; or by email to brad.ko@gmail.com