



Shared Ski Adventures Student Medical Form



Student Name: _____ DOB: _____

Family Physician: _____ Phone: _____

Physician's Address: _____

_____ City State Zip

Diagnosis: _____

Health Insurance Provider: _____

Policy Holder: _____ Policy #: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS.
YOUR RESPONSES WILL HELP US PLAN HOW WE CAN BEST MEET YOUR NEEDS.

Do you use any of the following adapted equipment? No, I do not use any adapted equipment

- Braces Crutches Manual Wheelchair Power Wheelchair
- Walker Other: _____

How do you communicate?

- Verbally Limited vocabulary Non-verbal, sign Non-verbal, PECS
- Other: _____

Can you communicate your basic needs? (hungry, thirsty, cold, bathroom) **YES NO**

Do you have a seizure disorder? **YES NO**

- My seizures are well-regulated with medication; if I have a seizure, *call 911 immediately*
- If yes, list the date of the last seizure: _____
- How often do they occur? _____
- What may trigger a seizure? _____
- What are signs that you are experiencing a seizure? _____

Please check any of the following boxes that may be an area of concern and provide a brief explanation.

- Hearing impairment _____
- Visual impairment _____
- Sensory loss _____
- Behavioral issues _____
- Safety awareness _____
- Fine motor skills _____
- Gross motor skills _____
- Balance _____
- Other: _____

Please complete both sides of this form

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Please provide any additional information that you believe is pertinent for the ski instructors to know.

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Signature: _____ Date: _____

Parent's Signature (if under 18 years): _____ Date: _____

Physician Signature: _____ Date: _____

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Please return your completed Medical & Registration Forms to:

**CP Rochester
Attn: Recreation / SSA
3399 Winton Road South
Rochester, NY 14623**

Please complete both sides of this form