BURKE REHABILITATION HOSPITAL: ADAPTIVE RECREATION 2018

Before your participation in Burke's Adaptive Recreation program, this form must be completed in its entirety. This information is essential to our ability to facilitate a successful experience.
All sections should be completed. Please be thorough and accurate.

Today's Date (MM/DD/YYYY): ____ /____ /_____

Name(s) & Date(s) of clinics/program(s) you are registering for: _____

_____

Contact/Biographical Information

Participant Name:_____ Home Phone:_____

Email: _____ Cell Phone: _____

Address: _____ City: _____ State: ___ Zip: _____

Name of Parent/Guardian (if applicable): _____

Relation to participant: _____ Parent/Guardian Phone: _____

Emergency Contact: _____ Relation:_____ Phone: _____

Primary Physician: _____ Physician Phone: _____
(If no primary physician, please list 2nd emergency contact) (or 2nd emergency contact number)

Disability/Medical Information

Date of Birth (MM/DD/YYYY): ____ /____ /_____ Height:_____ Weight:_____ Gender:_____

Participant Disability/Diagnosis:
(**PLEASE BE SPECIFIC HERE. LIST ANYTHING THAT MAY AFFECT YOUR PARTICIPATION!**)

_____
_____
_____

Are there any mental health/behavioral needs of which staff should be made aware?

_____

_____

If disability was caused by injury/incident, please give the date (MM/DD/YYYY): ____ /____ /_____

Any injuries/surgeries in the past year? _____

_____

Currently taking any medications? If yes, please list: _____

_____

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Allergies (food, medications, latex, bees, other)?: _____

Do you have a known anaphylaxis reaction to the allergen above? _____

If yes- do you carry and Epinephrine Auto Injector (EpiPen)? _____

If yes- do you give Burke permission to administer your epinephrine to you, if you are unable to do so? _____

Subject to seizure? _____ Date of last seizure (MM/DD/YYYY): ____ /____ /_____

Seizure management (Meds, etc.) _____

Can participant wear a helmet? _____

Please describe any other medical concerns that may affect participation: _____

_____

_____

Physical/Social Information

Mobility: ☐ Independent ☐ Independent (requires extra time) ☐ Needs assistance

Devices used to aid mobility (check all that apply):

☐ Braces ☐ Walker ☐ Cane ☐ Manual wheelchair ☐ Power wheelchair ☐ Crutches ☐ Other:

_____

Transfers: ☐ Independent ☐ Supervision ☐ Minimal ☐ Moderate ☐ Maximal

Please describe any and all pertinent information regarding transfers: _____

_____

Please describe any hearing and/or visual abilities and any special needs/concerns: _____

_____

Please describe any pertinent information regarding the participant's means of communications and interactions with others. Please include any stressors, motivators, or other relevant information.

_____

_____

_____

Continued >

Please describe your…	**Left Side**	**Right Side**
Arm strength		
Hand grip strength		
Arm/Hand sensation (numbness, tingling, etc.)		
Arm range of motion		
Leg strength		
Leg/Foot sensation (numbness, tingling, etc.)		
Leg range of motion		

How did you hear about us?

_____

_____

What activities are you (the participant) interested in participating in?

☐ Hand Cycling ☐ Snow Skiing ☐ Sailing ☐ Visual Arts ☐ Dance

☐ Rock Climbing ☐ Kayaking ☐ Yoga ☐ Creative Writing ☐ Recreation Outings

☐ Water Skiing ☐ Golf ☐ Table Tennis ☐ Theater/Improv ☐ Other

Please describe your experience with the selected activities above, including equipment adaptations, personal goals, and any other specific information that will help us prepare for your participation:

_____

_____

_____

_____

_____

Would you like to know more about our other programs, and stay up to date to our upcoming programs and available resources? (I.E. Fitness classes, fitness challenge, cycling races, fundraisers, wheelchair games, etc.)

☐ Yes! Email to reach you at: _____

☐ No thank you

BURKE ADAPTIVE RECREATION RELEASE

RELEASE OF LIABILITY (required)

I/we hereby for ourselves, our heirs, administrators and assigns, waive and release any and all claims against The Burke Rehabilitation Hospital and its employees, contractors and volunteers, for any and all injuries and/or expenses incurred by me/us while using any related recreation equipment (such as McClain Training Rollers, Quad Grips, helmets, Hand Cycles, Golf Clubs, Climbing Equipment, Kayaking Equipment, Table Tennis Equipment, etc.) during participation in clinics, classes, workshops, practices, training, rides or competition.

Printed Name of Participant: _____

Signature of Participant: _____ Date: _____

Legal Guardian: _____ Date: _____

Questions? Call (914) 597-2248 and leave a message.
We will return your call as soon as possible.

After you have completed this form in its entirety, please return to:

Therapeutic Recreation c/o Alexandra Oudheusden
Burke Rehabilitation Hospital
785 Mamaroneck Ave.
White Plains, NY 10605
AdaptiveSports@Burke.org
FAX: 914-597-2829

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