BURKE REHABILITATION: ADAPTIVE SPORTS & RECREATION

Before you participate in Burke's Adaptive Sports & Recreation program, this form must be completed in its entirety. This information is essential to our ability to facilitate a successful experience. All sections must be completed thoroughly and accurately. A physician must sign the medical form.

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

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

____

Contact/Biographical Information

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: ****BE SPECIFIC! LIST ALL THINGS THAT MAY AFFECT YOUR PARTICIPATION!*****

For Example Cardiac; Diabetes; Pulmonary; Orthopedic; etc.)

____

____

____

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? ____

____

Current Medications? Please list: ____

____

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?______

Have you ever had a seizure(s)? ________ 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 ☐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 Assistance ☐Moderate Assistance ☐Maximal Assistance

If you need help with transfers, do you have an aide? ____

Please describe all pertinent information regarding transfers: _______________________________________

____

Please describe any hearing and/or visual issues and any special needs/concerns: ______________________

____

Please describe any pertinent information regarding the participant's means of communication 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?

☐ Water Skiing	☐ Fishing	☐ Archery	☐ Field Events	☐ Pickleball
☐ Hand Cycling	☐ Snow Skiing	☐ Sailing	☐ Expressive Arts	☐ Dance
☐ Rock Climbing	☐ Kayaking	☐ Tennis	☐ Softball	☐ Power Soccer
☐ Boxing	☐ Golf	☐ Table Tennis	☐ Theater/Improv	☐ Other

Please describe your experience w/your selected activities, 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: ____

☐ 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:

Recreational Therapy c/o Eileen Andreassi
Burke Rehabilitation Hospital 785 Mamaroneck Ave.
White Plains, NY 10605
AdaptiveSports@Burke.org
FAX: 914-597-2829

OFFICE USE ONLY

Project: ____ Location: _____________ Date: ____ / ____ / ____

☐ M ☐ F Age: ________ Note: ____ *Rev 5/2020*

CONSENT AND RELEASE FOR USE OF IMAGES

I, ___________________________________, hereby agree to grant to Burke Rehabilitation Hospital its parents, successors, affiliates (hereinafter "Burke") and all persons acting under its permission or authority including, but not limited to, its parent, successors, affiliates (hereinafter "Burke") employees and other persons it may engage ("Licensees"), to interview me, have permission to photograph, publish, reproduce, record and use photographs, motion pictures, videotapes or audio tapes (collectively referred to as "Images") of me , in order to memorialize the medical care, surgery, any other procedures to be performed, my presence at Burke facilities, attendance at Burke events and/or participation in Burke research studies. The Images may be used for any and all purposes, including but not limited to distribution to the media, educational, promotional, publicity, advertising and fundraising purposes, as well as for possible publication by Burke in various traditional and social media (e.g. Facebook) and on the Internet. I acknowledge and agree that neither Burke will pay me, my children, or my legal ward while a patient at Burke in any manner for such photographing/ recording and use of the Images. I grant this permission and release as a voluntary contribution and I waive any and all rights I (or my child) may have to royalties or other compensation in connection with any such publication or use. I hereby waive my right to inspect and/or approve the finished products and final usages. I hereby release and discharge Burke from any liability by virtue of any blurring, distortion, alteration, optical illusion or use in composite form that may occur or be produced in the creation

or processing of any images created by Burke. The foregoing permission is granted for the entire time period during which I (or my child) receive(s) outpatient and inpatient treatment and the right to use the Images shall continue until such time that the footage, photographs and other images are no longer used by Burke for educational, promotional, publicity, commercial and fundraising purposes. I also understand that I may contact my attending physician or research study coordinator in writing to revoke future uses, but that my revocation will not affect disclosures of information that have already occurred. I understand that I am not required to sign this form authorizing the use of Images, and I may refuse to do so without any effect on my receipt of care at Burke.

I hereby release Burke, its trustees, officers, employees, physicians, agents and assigns from any and all legal liability that may arise from any of the foregoing and I waive any and all rights I (or my child) may have to royalties or other compensation in connection with any of the foregoing.

Name (PRINT): ______________________ Signature: ______________________

Address: ____________________________________ Date: ____/____/____

Email address (optional): ______________________ Phone: ______________

Witness:

Name (PRINT): ______________ Signature: ______________ Date: ____/____/____

MEDICAL CLEARANCE FORM

Your patient ________________________ has applied to participate in an Adaptive Sports & Recreation program at Burke Rehabilitation Hospital which requires your medical clearance prior to participation. Clearance indicates that this patient has no contraindications for participation in active sports or passive recreation activities.

My patient, ____________________________________ is physically able to participate in the Adaptive Sports & Recreation program.

Please list any restrictions or concerns (including medications).

____

____

COVID 19 Attestation: My Patient ____**had** ___**has not had COVID**. **If Yes: when?** ___________

Received ___**Moderna** Vaccine: _____1 dose _____Both Doses

___**Pfizer** Vaccine: _____1 dose _____Both Doses

___**Johnson & Johnson** Vaccine: ______1 dose

Doctors Details

Name: _______________________________________ Phone No: _________________________________

Email: ____

Address: ____

City: _______________________________________ State: ________________ Zip Code: ____________

Signature: _____________________________________ Date: _____________________________________

Please fax, email or return paper form to:

Eileen Andreassi, MA, CTRS
Director of Recreational Therapy & Adaptive Sports
Burke Rehabilitation Hospital
adaptivesports@burke.org
914-597-2248
914-597-2829 (fax)