



RETURNING PARTICIPANT APPLICATION

Please fill out the New Participant Application if it has been longer than 3 years since you last participated with us.

(Please Print)

If you need assistance in completing this application, please call our office and we will assist you: 207-824-2440.

PARTICIPANT INFORMATION

Last Name:	First Name:	Today's date:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
		Date of Birth:	
Mailing address:	City:	State	ZIP Code:
			County:

PHONE NUMBERS:

Home:	Cell:	Other:
Email:		Would you prefer to receive our information electronically? <input type="checkbox"/> Yes <input type="checkbox"/> No

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:	Emergency Contact Phone 1:	Emergency Contact Ph 2:	Relationship:
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GUARDIAN INFORMATION

Are you your own guardian?
 Yes No

If NO, please answer the following regarding your guardian:

Last Name:	First Name:	Relationship:	
Address:	City	State	ZIP Code
Phone 1:	Phone 2:	Email:	

Send Mail To (please check one): Participant Guardian Both Participant & Guardian

MEDICAL INFORMATION

DIAGNOSIS DETAILS

Disability/Diagnosis:	Date of Injury (If Applicable):	Briefly describe the nature and/or cause of your disability (for example: auto accident, blood clot, congenital, etc.).
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PHYSICIAN INFORMATION

Physician Name:	Physician Phone:	Physician Fax:
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SEIZURES & ALLERGIES

Do you have seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please answer the following questions regarding your seizures:				
Type of seizure:	Date of last seizure:	Are you currently taking medication for seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list.

Weight: _____ lbs.

Height _____ ft. ____ in.

MEDICAL INFORMATION CONTINUED

MOBILITY

Please indicate your **primary** mode of mobility:

- Walking
 Partial walking/partial wheelchair
 Wheelchair – Check one: MANUAL POWER

Please list any mobility aides used in ambulation:

Has there been any change in your medical condition in the past year? If so, please explain:

PARTICIPATION INFORMATION

Please check the activities in which you are interested in participating.
For the selected activities, indicate your current skill level.

SUMMER

	Beginner	Intermediate	Advanced
<input type="checkbox"/> Golf			
<input type="checkbox"/> Kayaking			
<input type="checkbox"/> Canoeing			
<input type="checkbox"/> Cycling			

WINTER

	Beginner	Intermediate	Advanced
<input type="checkbox"/> Alpine Skiing			
<input type="checkbox"/> Snowboarding			
<input type="checkbox"/> Snowshoeing			
<input type="checkbox"/> Nordic Skiing			

Are you Right or Left Handed?: Right Left

While wearing a PFD, are you able to turn from face down to face up in the water? Yes No

In what other sports are you involved?:

What was your most recent season of participation with MHS?

What is the total number of years you have participated with MHS?

The information contained on this application may be used internally by MHS staff and volunteer instructors.

Please return to: **Maine Handicapped Skiing**
8 Sundance Ln
Newry, ME 04261
207-824-0453 (fax)

If you email this form you need to save a copy and then email that copy to schedule @skimhs.org

2009/2010

OFFICE USE ONLY

Equipment Type _____

Date Received ____/____/____