Please Pick One

Please Select Group Name

Group Memgership:

Please select your course and corresponding dates.

Adventures Within ▼

Applicant Role

My Preferred Site: Select Site ▼

Instructor Request:

PERSONAL INFORMATION

Participant First Name:

Participant Middle Name:

Participant Last Name:

Date of Birth: Age:

Height: Weight: Gender: Preferred Pronouns

Weight limits: 200 pounds for sit down participants and 250 pounds for stand up participants.

Ethnicity ○ Not Declared ○ African American ○ Asian ○ Caucasian ○ Hispanic ○ Native American ○ Other

Contact Information

Address:

City: State: Zip: Country:

Phone #. No (), -, or /

Homephone (landline number): Workphone: Cellphone:

If you want emails to go to more than one address separate them with commas.

Email Address:

Emergency Contact

Name: Phone: Relationship:

Parent / Guardian Information (Leave blank if same as above)

First Name: ☐ Last Name: ☐

Homephone: ☐ Workphone: ☐ Cellphone: ☐

Address: ☐

Email: ☐

INSURANCE INFORMATION

Is the applicant covered by any medical care policy? ○ Yes ○ No

Medical Insurance Policy (carrier and type): ☐

Policy Number: ☐

(Please note: We recommend that all BOEC students be covered by personal health insurance. If medical care for injury, pre-existing condition or any other reason is required during a BOEC course, the student's personal health insurance will be primary.)

MILITARY

Military Background

Please select one

Please select one if you are associated with a Military Program:

Branch of Service: ☐

Rank: ☐

List the war(s) served in:

I have not served in any wars ☐

Do you have any combat or active duty related injuries or disabilities? ○ Yes ○ No

Geographic Location (country or conflict) where injury occurred: ☐

Date of Onset: ☐

Type or Diagnosis: ☐

Are you eligible to participate in VA programs and not debarred? ○ Yes ○ No

Please check all disabilities that apply to you. You must select at least one.

Additional comments, notes, or disabilities (if more than 5)

Have you skied/snowboarded with the BOEC before? ○ Yes ○ No

○ Unknown - I don't know what I can/want to do

Stand up Methods:

○ Unknown - I don't know what I can/want to do
○ Two Track - Regular downhill stand up skiing.
○ Three Track - Skiing on one leg with standup outriggers.
○ Four Track - Skiing on two legs with standup outriggers.
○ Slider - Stand up skiing on one or 2 legs using a walker on skis
○ Snowboard - Snowboarding with or without special equipment.
○ Nordic - Cross country skiing. With or without special equipment.
○ Nordic Slider - Stand up skiing on one or 2 legs using a walker on skis
○ Snowshoe - Walking on snow with snowshoes.

Sit Down Methods:

○ Bi-Ski - Sit skiing on a device with 2 skis attached.
○ Bi-Ski Fixed - Sit skiing on a device with 2 skis attached and 1 or more fixed outriggers for additional balance
○ Mono-Ski - Higher performance and harder to balance than a Bi-Ski. Only 1 ski attached.
○ Nordic Bi-Ski - Sit skiing on a device with 2 skis attached.
○ Ski Bike - Ride a Snow Bike

Experience Level:

Will you bring your own ski or snowboard? ○ Yes ○ No

Comments

Do you face a mobility challenge? Please check all that apply

Balance ☐	Dexterity ☐	Use Crutches ☐
Coordination ☐	Visual Impairment ☐	Use Manual Wheelchair ☐
Endurance/Fatigue ☐	SCI ☐	Use Cane ☐
Hemiplegia ☐	Use Power Chair ☐	Prosthetic ☐
Walk Independently ☐	Use Walker ☐	Other ☐

Please explain any of the above.

What equipment listed above do you use most often?

Do you have walking concerns? ○ Yes ○ No

Do you require assistance on uneven, rough terrain? ○ Yes ○ No

How far can you walk before resting?

Can you climb up and down stairs independently? ○ Yes ○ No

Can you climb independently into a canoe or raft? ○ Yes ○ No

Do you have a dominant side? ○ Left ○ Right ○ No

Wheelchair users please answer the following

Do you use your chair: ○ All the time ○ Only when fatigued ○ Only outside ○ Only away from home

Do you operate the wheelchair independently? ○ Yes ○ No

Do you require a mechanical lift to transfer into or out of a 15 passenger van? ○ Yes ○ No

Transfers: ○ No assist ○ Minimal Assist ○ Moderate Assist ○ Total Assist ○ Other

Weight Shifts Required? ○ Yes ○ No

Please describe the functional limitations in your upper body and hands?

How has your condition changed or improved since your diagnosis or previous visits to the BOEC? ○ Unchanged ○ Slightly Changed ○ Moderately Changed ○ Dramatically Changed

Please describe the areas in which you feel there have been the most significant changes in your life and lifestyle.

COMMUNICATION

Do you have any restrictions in your ability to communicate? ○ Yes ○ No

If yes, what kind of communication is best for you (check all that apply)? :

Verbal ☐Sign Language ☐Gestures ☐Communication Board ☐

Other ☐

Pease Describe

Can you understand what is said to you? ○ Yes ○ No

Can you express your needs? ○ Yes ○ No

How do you best express your needs?

EXPERIENCE

Have you ever participated in a BOEC course? ○ Yes ○ No

Most recent date:

Why are you interested in participating in this course?

General Information

Your place on a BOEC course is confirmed when we receive all required forms, completed and signed, your application has been approved by the BOEC, and your tuition is paid in full. The following information is held in complete confidence and is of critical importance. The Physicians examination must take place within six months prior to your course. We will call you and/or your physician with any questions concerning the information provided to the BOEC or your appropriateness for the course. The BOEC reserves the right to screen all applicants. If we think that you should not participate in a BOEC course, we will refund all tuition payments made to the BOEC. We cannot refund other costs that you incur in preparation for the course.

COURSE APPLYING FOR COURSE START DATE

FAMILY PHYSICIAN PHYSICIAN PHONE

PHYSICIAN FULL ADDRESS

Personal History

Do you use alcohol? ○ Yes ○ No If yes, how often?

Do you use tobacco? ○ Yes ○ No If yes, how often?

Have you been in counseling with a psychologist, psychiatrist or psychotherapist within the last year? ○ Yes ○ No

Are you currently in treatment? ○ Yes ○ No

Reason for treatment

Please contact your therapist and arrange for a release of information so we may contact her/him. Has this been done? ○ Yes ○ No

Therapist Information:

Name Address

City/State/Zip Phone

Email

Conditions and Symptoms

Conditions and Symptoms – Do or have you experienced any of the following? Check all that apply.

☐ High Blood Pressure

Please Describe

☐ Communicable Disease

Please Describe

☐ Heart Disease

Please Describe

☐ Head Injury

Please Describe

☐ Heart Murmur

Please Describe

☐ Heatstroke

Please Describe

☐ Family History of Heart Attack

Please Describe

☐ Bladder Infection

Please Describe

☐ Irregular Heartbeat

Please Describe

☐ Difficulty Urinating

Please Describe

☐ Tuberculosis

Please Describe

☐ Kidney Problems

Please Describe

☐ Recent exposure to active TB

Please Describe

☐ Thyroid Problems

Please Describe

☐ Positive TB skin test

Please Describe

☐ Endocrine Problems

Please Describe

☐ Active Hepatitis

Please Describe

☐ Hearing Impairment

Please Describe

☐ Bleeding Disorder

Please Describe

☐ Motion Sickness

Please Describe

☐ Asthma

Please Describe

☐ Sleep Walking

Please Describe

☐ Diabetes

Please Describe

☐ Broken Bones

Please Describe

☐ Hypoglycemia

Please Describe

☐ Neck Problems

Please Describe

☐ Anorexia Nervosa

Please Describe

☐ Back Problems

Please Describe

☐ Bulimia

Please Describe

☐ Arm or Shoulder Problems

Please Describe

☐ Cancer

Please Describe

☐ Leg, Knee or Ankle Problems

Please Describe

☐ Skin Problems

Please Describe

☐ Foot Problems

Please Describe

☐ Frostbite

Please Describe

☐ Currently Pregnant

Please Describe

☐ Circulation Problems

Please Describe

☐ Special Diet

Please Describe

☐ Active Bedwetting

Please Describe

☐ Learning Disability

Please Describe

☐ Headaches

Please Describe

☐ Anemia, Sickle cell trait or other blood condition

Please Describe

☐ Stomach Ulcers

Please Describe

☐ Medical Equipment Devices

Please Describe

☐ Intestinal Problems

Please Describe

☐ Altitude Problems

More Information

☐ Other

Please Describe

Do you currently or regularly have any of the following symptoms?

☐ Chest Pain/Pressure

Please Describe

☐ Heartburn

Please Describe

☐ Heart Palpitations

Please Describe

☐ Muscle Cramps

Please Describe

☐ Unexplained Sweating

Please Describe

☐ Intolerance of Cold Temps

Please Describe

☐ Frequent Shortness of Breath

Please Describe

☐ Intolerance of Warm Temps

Please Describe

☐ Frequent Dizziness

Please Describe

☐ PMS or Menstrual Problems

Please Describe

☐ Frequent Fainting

Please Describe

☐ Muscle Spasms

Please Describe

Seizure Specific Information

Have you been diagnosed as having a Seizure Disorder? ○ Yes ○ No

If yes, what is the specific type of

Seizure Frequency Current Status ○ Active ○ Controlled

Describe your seizure. Do you have any warning? What is the after effect of the seizure?

Describe specific care required in the event of a seizure and recovery time.

Medications

Please list any medications that you are currently taking, include over the counter medications. If you will be receiving medication during the course, please bring double amounts, in separate, waterproof containers. If the applicant will need assistance with medication, please fill out Prescription Medication Form

NAME	DOSAGE / TIMES PER DAY	REASON

Allergies

List all allergies, including any to medications.

ALLERGY	REACTION	MEDICATION REQUIRED

Immunization

The BOEC requires a tetanus immunization within 10 years of course start date. Please indicate the date, including the year of student's last tetanus immunization

The Breckenridge Outdoor Education Center reserves the right to require an exam, by a qualified medical practitioner, for any applicant to a BOEC course.