Please Pick One

Please Select Group Name

Group Memgership:

Applicant Role

My Preferred Site: Select Site ▼

Instructor Request:

PERSONAL INFORMATION

Participant First Name:

Participant Middle Initial:

Participant Last Name:

Date of Birth: Age: Developmental Age (if applicable):

Height: Weight: Gender:

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

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

Contact Information

Address:

City: State: Zip:

Phone numbers. It's best to enter only digits. Please no extra characters.

Homephone (landline number): Workphone: Cellphone:

Enter valid email addresses. 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: Employer:

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

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 select one if you are associated with a Military Program:

Please Check All Disabilities That Apply to You.

☐ None

☐ Allergies

More Information

☐ Altitude Problems

More Information

☐ ALS (Amyotrophic lateral sclerosis) Lou Gehrig's

Date of Onset

○ Sporadic ○ Familial

More Information

☐ Amputations

☐ AK Right ☐ BK Right ☐ AE Right ☐ BE Right

☐ AK Left ☐ BK Left ☐ AE Left ☐ BE Left

☐ Shoulder Right ☐ Hip Right

☐ Shoulder Left ☐ Hip Left

Date of Onset

Prosthetic Details

☐ Angelman’s Syndrome

More Information

☐ Asthma

Triggers

Inhaler

☐ Autism Spectrum

☐ ADD
☐ ADHD

☐ Aspergers
☐ Sensory Processing Disorder
☐ Pervasive Developmental Disorder
☐ Rhetts Syndrome
☐ Executive Functioning

☐ Verbal
☐ Non-verbal

More Information

☐ Brain Injury

Date of Onset

☐ CVA/Stroke
☐ TBI
☐ Shunt
☐ Right side Affected
☐ Left side Affected

Memory Loss ○ Mild ○ Moderate ○ Severe

History of Concussions: ○ Yes ○ No

Last Concussion Occurred On:

More Information

☐ Cardiac

☐ Irregular Heartbeat ☐ Heart Murmur ☐ Heart defect

☐ Hypotension ☐ Hypertension

Heart Attack

Date:

Surgery:

Stint:

More Information

☐ Cancer

Date Of Onset:

Diagnosis:

Treatment:

Date of Surgeries:

Date of Remission:

More Information

☐ Cerebral Palsy

○ Flaccid ○ Spastic ○ Athetoid ○ Ataxic

More Information

☐ Cognitive / Developmental

Cognitive Age

Speech Impairment

☐ Verbal
☐ Non Verbal

☐ Learning Delays
☐ Emotional
☐ Fine Motor Skills
☐ Separation Anxiety

Please Describe

☐ Diabetes

Date of Onset

☐ Insulin ☐ Type 2 ☐ Hypoglycemia

☐ Glucometer

Neuropathy

☐ Hands
☐ Feet

☐ Dietary Restrictions / Needs

☐ Gluten Free ☐ Celiac ☐ Diary Free

☐ Lactose Intolerant ☐ Vegetarian ☐ Vegan

☐ No artificial coloring ☐ Sugar Free ☐ Diabetic

Nut Allergy

☐ Down Syndrome

More Information

☐ Hearing Impairments

Type

Date of Onset

○ Partial ○ Full

☐ Right Side ☐ Left Side

☐ Hearing Aids ☐ Reads Lips ☐ Sign Language (ASL)

☐ Cochlear Implant

Date

☐ Hemophilia

Date of Onset

○ Hemophilia A ○ Hemophilia B ○ Von Willebrand ○ Other Factor Deficiencies

Other Factor Deficiencies

☐ Mental Health

☐ Anxiety ☐ Bi Polar ☐ Depression ☐ Frustration/ Anger

☐ Schizophrenia ☐ Substance abuse ☐ Panic Attacks

Other

☐ Multiple Sclerosis

Date of Onset

○ Clinically Isolated Syndrome (CIS) ○ Relapsing-remitting (RRMS) ○ Primary Progressive (PPMS) ○ Secondary Progressive (SPMS)

More Information

☐ Muscular Dystrophy

Date of Onset

○ Duchenne ○ Becker ○ Steinert's (Myotonic)

○ Facioscapulohumeral (FSHD) ○ Congential ○ Limb-girdle

More Information

☐ Parkinson's

Date Of Onset

☐ Temors ☐ Bradykinsia ☐ Rigidity ☐ Postural Instability

☐ PTSD

Military Related ☐

Date Of Onset:

Triggers:

What Helps You Calm Down:

☐ Seizures

Date Of Onset

☐ PetitMal
☐ GrandMal
☐ Tonic Clonic

Last Seizure

Please provide details including recovery plan

☐ Spina Bifida

☐ Spina bifida occulta

☐ Meningocele

☐ Myelomeningocele

More Information

☐ Spinal Cord Injury

Date of Onset

Level

○ Complete ○ Incomplete

More Information

☐ Visual Impairment

Type:

Date of Onset

○ Partial ○ Full

☐ Uses corrective Lenses

☐ Uses Cane ☐ Guide Dog

☐ Williams Syndrome

More Information

☐ Other

More Information

MOBILITY: (must be checked before you can move on)

Walking	Uses Assisted Devices	Physical Concerns	Transfer help
○ No Assistance Needed (independent/ambulatory)	☐ Crutches	Upper Body Strength	☐ Independent
○ Some Assistance Needed	☐ Walker	☐ Poor	☐ Minimal Assist
	☐ Braces/AFO	☐ Fair	☐ Total Assist
Balance	☐ Cane	☐ Good	Do you have a dominant side?
○ Good	Wheelchair	Lower Body Strenght	☐ Right
○ Fair	☐ Power	☐ Poor	☐ Left
○ Poor	☐ Manual	☐ Fair	
How far can you walk before needing rest?		☐ Good	
More Information			