

Please Pick One

Please Select Group Name

Group Membership:

Applicant Role

My Preferred 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 Native American
 Other

Contact Information

Address:

City: State: Zip: Country:

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 Dairy 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) Congenital 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
<input type="radio"/> No Assistance Needed (independent/ambulatory)	Crutches <input type="checkbox"/>	Upper Body Strength	Independent <input type="checkbox"/>
<input type="radio"/> Some Assistance Needed	Walker <input type="checkbox"/>	Poor <input type="checkbox"/>	Minimal Assist <input type="checkbox"/>
	Braces/AFO <input type="checkbox"/>	Fair <input type="checkbox"/>	Total Assist <input type="checkbox"/>
Balance	Cane <input type="checkbox"/>	Good <input type="checkbox"/>	Do you have a dominant side?
<input type="radio"/> Good	Wheelchair	Lower Body Strength	Right <input type="checkbox"/>
<input type="radio"/> Fair	Power <input type="checkbox"/>	Poor <input type="checkbox"/>	Left <input type="checkbox"/>
<input type="radio"/> Poor	Manual <input type="checkbox"/>	Fair <input type="checkbox"/>	
How far can you walk before needing rest?		Good <input type="checkbox"/>	
<input type="checkbox"/>			
More Information			