

**Please Pick One**

Please Select Group Name

Group Memgership:

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  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       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)    Congenial    Limb-girdle

More Information



Parkinson's

Date Of Onset

Tremors  Bradykinesia  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)	<input type="checkbox"/> Crutches	Upper Body Strength	<input type="checkbox"/> Independent
<input type="radio"/> Some Assistance Needed	<input type="checkbox"/> Walker	<input type="checkbox"/> Poor	<input type="checkbox"/> Minimal Assist
	<input type="checkbox"/> Braces/AFO	<input type="checkbox"/> Fair	<input type="checkbox"/> Total Assist
Balance	<input type="checkbox"/> Cane	<input type="checkbox"/> Good	Do you have a dominant side?
<input type="radio"/> Good	Wheelchair	Lower Body Strength	<input type="checkbox"/> Right
<input type="radio"/> Fair	<input type="checkbox"/> Power	<input type="checkbox"/> Poor	<input type="checkbox"/> Left
<input type="radio"/> Poor	<input type="checkbox"/> Manual	<input type="checkbox"/> Fair	
How far can you walk before needing rest?		<input type="checkbox"/> Good	
More Information			