



Participant Information Sheet

Please fill out this application completely and accurately and return via:
 Fax to 435.658.3992 or mail to PO BOX 682799 Park City, UT 84098 or email to registration@DiscoverNAC.org

<p style="text-align: center;">NAC PARTICIPANT</p> <p>Name: _____</p> <p>Age: _____ Date of Birth: ____/____/____</p> <p>Male ____ Female ____ Height: _____ Weight: _____</p> <p>Address: _____</p> <p>_____</p> <p>Home Phone: _____</p> <p>Cell Phone: _____</p> <p>Email: _____</p> <p>Diagnosis- Primary: _____</p> <p>Secondary: _____ Details: _____</p> <p>_____</p> <p>Primary language spoken/understood: _____</p> <p>Have there been any seizures in the last year? Yes ____ No ____</p> <p>If yes, when? _____</p> <p>Type of seizure? _____</p> <p>Is the participant ambulatory? Yes ____ No ____</p> <p>Primary means of mobility (i.e. power wheelchair, manual wheelchair, cane, walker, etc)?</p> <ol style="list-style-type: none"> 1. _____ 2. _____ 3. _____ <p>Please check if participant serves or has served in the U.S. Military. ____</p>	<p style="text-align: center;">PARENT/GUARDIAN/CAREGIVER INFORMATION</p> <p>Name: _____</p> <p>Relation: _____</p> <p>Address: _____</p> <p>_____</p> <p>Home Phone: _____</p> <p>Cell Phone: _____</p> <p>Work Phone: _____</p> <p>Email: _____</p>
<p style="text-align: center;">EMERGENCY CONTACT INFORMATION (If different from Parent/Guardian/Caregiver)</p> <p>Name: _____</p> <p>Relation: _____</p> <p>Home Phone: _____</p> <p>Cell Phone: _____</p> <p>Work Phone: _____</p> <p>_____</p> <p>Name: _____</p> <p>Relation: _____</p> <p>Home Phone: _____</p> <p>Cell Phone: _____</p> <p>Work Phone: _____</p>	

General Information

What are your favorite activities or topics? _____

Any fears or dislikes? _____

Family Do's and Don'ts: _____

Anything else we should know? _____

<p><u>Physical Concerns</u></p> <p>____ No concerns (If there are no concerns, skip ahead to Sensory)</p> <p>Is the participant proficient in the following skills? Mark with 'X' for yes:</p> <p>__ Sits unassisted - If yes, for how long? _____</p> <p>__ Stands unassisted - If yes, for how long? _____</p> <p>__ Walks unassisted</p> <p>__ Runs unassisted</p> <p>__ Uses hands independently</p> <p>__ Releases objects</p> <p>__ Bears weight on hands</p> <p>__ Climbs stairs</p> <p>__ Bears weight on legs</p>	<p>Describe general balance: _____</p> <p>_____</p> <p>Concerns with temperature: _____</p> <p>_____</p> <p>Concerns with Pressure sores/ skin breakdown: _____</p> <p>_____</p> <p>Shunt/catheters: _____</p> <p>Concerns with Muscle spasms/tightness: _____</p> <p>_____</p> <p>Concerns with Speech: _____</p> <p>Hand/eye coordination: _____</p> <p>Are you extra sensitive to the sun? Yes ____ No ____</p> <p>Endurance: _____</p> <p>Are you extra sensitive to hot/cold temperatures? Yes ____ No ____</p> <p>Transfers (please circle one): No Assist Partial Assist Total Assist</p>
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Sensory Concerns

No concerns (If there are no concerns, skip ahead to

Cognition/Processing)

Please mark applicable concerns below with an 'X':

Vision:

Partially sighted/legally blind

Totally blind

Please describe the amount of vision the participant has:

Hearing:

Partial hearing loss

Total hearing loss

Please describe how he/she best communicates:

Please describe sensitivities in the following areas:

Visual (seeing): _____

Auditory (hearing): _____

Olfactory (smelling): _____

Tactile (touching): _____

Proprioceptive (movement): _____

What sensory situations upset him/her? _____

Assistive technology used: _____

Cognition and Processing No Concerns (if there are no concerns in the following areas, skip ahead to **Behavioral**)

Is the participant proficient in the following skills? Mark with an 'X' for yes:

Educational

- Knows numbers
- Knows letters
- Knows left/right
- Knows prepositions
- Communicates feelings
- Makes choices

Social

- Recognizes name
- Makes eye contact
- Waves: says hi/bye
- Shares toys/items
- Knows safety awareness
- Interacts with peers
- Appropriate conversation
- Takes turns
- Understands personal space

Language

- Makes sounds
- Says words
- Combines 2 or more words
- Speaks in complete sentences
- Understands "No"
- Letter sound identification
- Signs or uses gestures
- Uses picture symbols

Follows Directions: 1-step 2-step 3-step Complex

Attention to task: Poor (0-1 min) Fair (1-5 min) Avg (5 min)

Frustration Tolerance: Poor Fair Average

Problem Solving: Poor Fair Average

Learning Style: Visual/learns by seeing Auditory/learns by hearing Kinesthetic/learns by doing

Behavioral No Concerns (if there are no concerns in the following areas, skip ahead to **Medical Information**)

Does the student have any behavior issues? Yes No If yes, please explain _____

Show violence? Yes No If yes, please explain _____

Successful Intervention Strategies used (behavioral, rewards, consequences, etc.): _____

Medical Information Please list all medications the participant is currently taking. Attach additional pages if needed.

Does the participant ever experience altitude sickness? Yes No Not sure

Does the participant ever experience motion sickness? Yes No Not sure

Medication	Schedule	Reason	Side Effect

Dietary Restrictions Please list any food restrictions.

Allergies Please list ALL known allergies (foods, environmental, medications, animals, etc).

Allergy	Reaction	Control Techniques/Medications

Program Specific

Please answer the following questions with/for the participant.	YES	NO
Are you capable of swimming independently?		
Are you capable of independently lifting your arms above your head?		
Are you capable of independently rolling over when face-down in water?		
Are you capable of independently grasping a rope?		
Are you capable of physically signaling for help?		
Are you capable of yelling for help?		
Are you capable of communicating pain?		
Have you participated in any of the following activities in your current state of health:		
• Canoeing?		
• Rock Climbing?		
• Skiing / Snowboarding?		
• Nordic Skiing/Snow Shoeing?		
• Water Skiing?		
• Archery?		

Please state your experience in the following sports. Include type of equipment used (adaptive/non-adaptive) and skill level. If no experience, write 'none.'

Can the participant ride a bike? ___ Yes ___ No
If yes, what type? ___ bicycle ___ tricycle ___ recumbent ___ hand cycle ___ other

Has the participant ridden a horse? ___ Yes ___ No If yes, what kind? ___ Pony Ride ___ Western ___ English ___ Trail Ride
Did you need assistance? ___ Yes ___ No If yes, what kind? ___ Lead walker ___ Side walker ___ Not sure

Has the participant skied before? ___ Yes ___ No If yes, what kind? ___ Stand ___ Bi-ski ___ Mono-ski ___ Walker ___ other

Personal Care/Independence The National Ability Center does not provide personal care. If you or the participant needs assistance in the below areas, you will need to provide an aide/caretaker.

Please circle the most appropriate answer:

- Toileting: Independent Partial Assist Total Assist
- Bladder Control: Normal Occasional Incontinent
- Bowel Control: Normal Occasional Incontinent
- Dressing: Independent Partial Assist Total Assist
- Eating: Independent Partial Assist Total Assist

Will a care provider be attending the program with the participant? ___ Yes ___ No