

*Please make sure you have read the [HOW TO REGISTER](#) document for registration process.*



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NATIONAL  
ABILITY  
CENTER

# PARTICIPANT PACKET

**You can register by mail, fax or email:**

**Mail paperwork to:**  
PO Box 682799, Park City, UT 84068

**Fax paperwork to:**  
435.658.3992

**Email paperwork to:**  
[registration@DiscoverNAC.org](mailto:registration@DiscoverNAC.org)



# National Ability Center

## Membership Application / Renewal

### 2011-2012

PLEASE MAIL, FAX OR EMAIL COMPLETED FORM TO:

1000 Ability Way, Park City, UT 84060 | f: 435.658.3992 | info@DiscoverNAC.org

### Contact Information

Name \_\_\_\_\_ Email \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Address 2 \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone #'s: Home ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

Gender (circle one): Male Female Disability \_\_\_\_\_

Military service: \_\_\_ None | \_\_\_ Current | \_\_\_ Former Branch \_\_\_\_\_

Membership Fees: \_\_\_ Individual (\$20) | \_\_\_ Family (\$30) | \_\_\_ Business (\$50) | \_\_\_ Lifetime (\$500)

Participant Groups & Organizations: \_\_\_ (fewer than 9 participants) \$50 | \_\_\_ (9 or more participants) \$100

Additional Family Members:

| Name | Relationship | Date of Birth | Disability (if any) | Gender |
|------|--------------|---------------|---------------------|--------|
|      |              |               |                     | M F    |
|      |              |               |                     | M F    |
|      |              |               |                     | M F    |
|      |              |               |                     | M F    |

### Freedom Man Society Major Gifts Program

In addition to your membership, we welcome your investment in our mission through participation in the Freedom Man Society. The Freedom Man is the primary symbol and logo for the National Ability center and represents the opportunities each individual has to discover self-esteem, confidence and physical development by participating in recreational sports and cultural activities.

Members of the Freedom Man Society honor our commitment to providing those opportunities through the development of high-quality, affordable programs. With only 20% of the true costs of programs covered by our program fees, your support is vital to continuing this commitment.



Donation Levels:

- \_\_\_ Patron | \$7,500
- \_\_\_ Associate | \$3,500 - \$7,499
- \_\_\_ Benefactor | \$1,000 - \$3,499
- \_\_\_ Supporter | \$750 - \$999
- \_\_\_ \$250
- \_\_\_ \$100
- \_\_\_ \$50
- \_\_\_ \$25
- \_\_\_ Other: \_\_\_\_\_

### Method of Payment

Credit Card Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

\*\* We accept Visa, MasterCard & American Express \*\*

Name on Card \_\_\_\_\_ Signature of Cardholder \_\_\_\_\_

Checks should be made payable to the National Ability Center *Thank you for your investment in our mission!*

STAY IN TOUCH WITH THE NATIONAL ABILITY CENTER

p: 435.649.3991 | DiscoverNAC.org | Twitter.com/AbilityCenter | Facebook.com/NationalAbilityCenter



# 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

## NAC PARTICIPANT

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Male \_\_\_\_ Female \_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
Diagnosis- Primary: \_\_\_\_\_  
Secondary: \_\_\_\_\_ Details: \_\_\_\_\_

Primary language spoken/understood: \_\_\_\_\_  
Have there been any seizures in the last year? Yes \_\_\_\_ No \_\_\_\_  
If yes, when? \_\_\_\_\_  
Type of seizure? \_\_\_\_\_  
Is the participant ambulatory? Yes \_\_\_\_ No \_\_\_\_  
Primary means of mobility (i.e. power wheelchair, manual wheelchair, cane, walker, etc)? \_\_\_\_\_

Program(s) Registering for: \_\_\_\_\_

Please check if participant serves or has served in the U.S. Military.  
\_\_\_\_\_

## PARENT/GUARDIAN/CAREGIVER INFORMATION

Name: \_\_\_\_\_  
Relation: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
Email: \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION

(If different from Parent/Guardian/Caregiver)

Name: \_\_\_\_\_  
Relation: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
Name: \_\_\_\_\_  
Relation: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_

## General Information

What are your favorite activities or topics? \_\_\_\_\_  
Any fears or dislikes? \_\_\_\_\_  
Family Do's and Don'ts: \_\_\_\_\_  
Anything else we should know? \_\_\_\_\_

## Physical Concerns

\_\_\_\_ No concerns (If there are no concerns, skip ahead to **Sensory**)

Is the participant proficient in the following skills?

Mark with 'X' for yes:

- \_\_\_\_ Sits unassisted  
    - If yes, for how long? \_\_\_\_\_
- \_\_\_\_ Stands unassisted  
    - If yes, for how long? \_\_\_\_\_
- \_\_\_\_ Walks unassisted
- \_\_\_\_ Runs unassisted
- \_\_\_\_ Uses hands independently
- \_\_\_\_ Releases objects
- \_\_\_\_ Bears weight on hands
- \_\_\_\_ Climbs stairs
- \_\_\_\_ Bears weight on legs

Describe general balance: \_\_\_\_\_  
Concerns with temperature: \_\_\_\_\_  
Concerns with Pressure sores/ skin breakdown: \_\_\_\_\_  
Shunt/catheters: \_\_\_\_\_  
Concerns with Muscle spasms/tightness: \_\_\_\_\_  
Concerns with Speech: \_\_\_\_\_  
Hand/eye coordination: \_\_\_\_\_  
Are you extra sensitive to the sun? Yes \_\_\_\_ No \_\_\_\_  
Endurance: \_\_\_\_\_  
Are you extra sensitive to hot/cold temperatures?  
Yes \_\_\_\_ No \_\_\_\_  
Transfers (please circle one):  
                    No Assist                  Partial Assist                  Total Assist

**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

**NATIONAL ABILITY CENTER INSURANCE WAIVER &  
RELEASE OF LIABILITY FORM and MEDIA RELEASE FORM**

**Please note: there are two places on this sheet that require a signature**

In consideration of being allowed to participate in any way in NATIONAL ABILITY CENTER'S programs, related events, and activities, I and/or the minor participant, for myself, and on behalf of my heirs, assigns, personal representatives and next of kin, the undersigned:

1. Acknowledge and fully understand that I and/or the minor participant, will be engaging in activities that involve risk of serious injury, including permanent disability and death, and severe social and economic losses which might result only from my own actions, inactions or negligence of others, the rules of play, or the condition of the premises or any equipment used. Further, that there may be other risks not known to me or not reasonably foreseeable at this time.
2. Acknowledges that although the National Ability Center has taken reasonable steps to provide me and/or the minor participant with appropriate equipment and skilled staff for the program for which I have applied and any other to which I may transfer, that the activities of the program(s) have
3. Assume all the foregoing risks and accept personal responsibility for the damages following such injury, permanent disability or death.
4. Release, waive, discharge and covenant not to sue NATIONAL ABILITY CENTER, its affiliated clubs, their representative administrators, directors, agents, coaches, and other employees of the organization, other participants, sponsoring agencies, sponsors, advertisers, their heirs, and if applicable, owners and leasers of premises used to conduct the event, all of which are hereinafter referred to as "releasees", from demands, losses or damages on account of injury, including death or damage to property, caused or alleged to be caused in whole or in part by the negligence of the releasee or otherwise.

**I/WE HAVE READ THE ABOVE WAIVER AND RELEASE, UNDERSTAND THAT I/WE HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, HAVE NOT CHANGED IT ORALLY, AND SIGN IT VOLUNTARILY.**

X \_\_\_\_\_  
**Participant's Name (PLEASE PRINT CLEARLY)                      Signature    Date**

**FOR PARTICIPANTS UNDER THE AGE OF 18**

This is to certify that I, as parent/guardian with legal responsibility for this participant, do consent and agree to his/her release as provided above of the Releasees, and, for myself, my heirs, assigns, and next of kin, I release and agree to indemnify and hold harmless the Releasees from any and all liabilities incident to my minor child's involvement or participation in these programs as provided above, EVEN IF ARISING FROM THEIR NEGLIGENCE.

X \_\_\_\_\_  
**Parent's Signature & Emergency Phone    Name & Date (PLEASE PRINT CLEARLY)**

***MEDIA RELEASE FORM***

Name \_\_\_\_\_ Age \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
**(PLEASE PRINT CLEARLY)**

**MEDIA/PHOTO WAIVER:**

\_\_\_\_\_ I hereby authorize and give my full consent to NATIONAL ABILITY CENTER to copyright and/or publish any and all photographs, videotapes and/or film in which I appear while attending this NATIONAL ABILITY CENTER event. I further agree that NATIONAL ABILITY CENTER may transfer, use or cause to be used, these photographs, videotapes, or films for any exhibitions, public displays, publications, commercials, art and advertising purposes, and television programs without limitations or reservations.

\_\_\_\_\_ I do not give my consent to the National Ability Center to copyright, publish, transfer or otherwise use any photographs, videotapes or films in which I appear while attending this NATIONAL ABILITY CENTER event.

X \_\_\_\_\_  
**Signature of Participant (or Guardian if under 18)    Date**



# Authorization for Emergency Medical Treatment

In the event emergency medical aid/treatment is required due to illness or injury during the process of participating in National Ability Center programs, or while being on the property of the National Ability Center, I authorize the National Ability Center staff to:

1. Secure and retain medical treatment and transportation if needed.
2. Release participant records upon request to the authorized individual or agency involved in the medical treatment.

Participant's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

*In the event of emergency, please contact:*

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

## Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any procedure deemed "life-saving" by the physician. This provision will only be invoked if the person listed below is unable to respond.

Consent Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Participant/Guardian)

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

## Non-Consent Plan

I do not give my permission for emergency medical treatment/aid in the case of illness or injury during the process of participating in National Ability Center programs or while being on the property of the National Ability Center. In the event emergency treatment/aid is required, I wish the following procedures to take place: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Non-Consent Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Participant/Guardian)

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_



# **National Ability Center**

## **MEDICAL HISTORY**

Date: \_\_\_\_\_

Thank you for your interest in participating in programs with the National Ability Center (hereafter referred to as the *NAC*). In order to safely provide this service, the NAC requests that you complete/update the attached Medical. Please note that the following conditions may suggest precautions and contraindications to participation in some programs. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

### **Orthopedic**

Atlantoaxial Instability – include neurologic symptoms  
Coxarthrosis  
Cranial Defects  
Heterotopic Ossification/Myositis Ossificans  
Joint subluxation/dislocation  
Osteoporosis  
Pathologic Fractures  
Spinal Joint Fusion  
Spinal Joint Instability/Abnormalities

### **Neurologic**

Hydrocephalus/Shunt  
Seizure  
Spina Bifida/Chiari II Malformation/Tethered Cord/Hydromyelia

### **Other**

Age – under 4 years  
Indwelling Catheters/Medical Equipment  
Medications – i.e. Photosensitivity  
Poor Endurance  
Skin Breakdown

### **Medical/Psychological**

Allergies  
Animal Abuse  
Cardiac Condition  
Physical/Sexual/Emotional Abuse  
Blood Pressure Control  
Dangerous to Self or Others  
Exacerbations of Medical Conditions (i.e. RA, MS)  
Fire Settings  
Hemophilia  
Medical Instability  
Migraines  
PVD  
Respiratory Compromise  
Recent Surgeries  
Substance Abuse  
Thoughts Control Disorders  
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns, please feel free to contact the NAC at [registration@discovernac.org](mailto:registration@discovernac.org) or 435-649-3991.

Sincerely,

NAC Program Staff



# National Ability Center

## MEDICAL HISTORY

Participant: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_  
 Past/Prospective Surgeries: \_\_\_\_\_  
 Medications: \_\_\_\_\_  
 Seizure Type: \_\_\_\_\_ Controlled: Y N Date of Last Seizure: \_\_\_\_\_  
 Shunt Present: Y N Date of last revision: \_\_\_\_\_  
 Special Precautions/Needs: \_\_\_\_\_

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N  
 Braces/Assistive Devices: \_\_\_\_\_

*For those with Down Syndrome:* AtlantoDens Interval X-rays, date: \_\_\_\_\_ Result: +  
 -

Neurologic Symptoms of Atlanto Axial Instability: \_\_\_\_\_

*Please indicate current or past special needs in the following systems/areas, including surgeries:*

|                         | Y | N | Comments |
|-------------------------|---|---|----------|
| Auditory                |   |   |          |
| Visual                  |   |   |          |
| Tactile Sensation       |   |   |          |
| Speech                  |   |   |          |
| Cardiac                 |   |   |          |
| Circulatory             |   |   |          |
| Integumentary/Skin      |   |   |          |
| Immunity                |   |   |          |
| Pulmonary               |   |   |          |
| Neurologic              |   |   |          |
| Muscular                |   |   |          |
| Balance                 |   |   |          |
| Orthopedic              |   |   |          |
| Allergies               |   |   |          |
| Learning Disability     |   |   |          |
| Cognitive               |   |   |          |
| Emotional/Psychological |   |   |          |
| Pain                    |   |   |          |
| Other                   |   |   |          |

*Please check which programs this individual is cleared to participate in:*

- |  |   |                                      |
|--|---|--------------------------------------|
| <input type="checkbox"/> Alpine Skiing/Snowboarding      | <input type="checkbox"/> Unmounted Equine Activities      | <input type="checkbox"/> Waterskiing |
| <input type="checkbox"/> Archery                         | <input type="checkbox"/> Ropes Course/Climbing Wall       | <input type="checkbox"/> Canoeing    |
| <input type="checkbox"/> Aquatics                        | <input type="checkbox"/> Cycling                          | <input type="checkbox"/> Summer Camp |
| <input type="checkbox"/> Therapeutic Riding/Hippotherapy | <input type="checkbox"/> Cross Country Skiing/Snowshoeing | <input type="checkbox"/> Sled Hockey |



# **National Ability Center**

## **STATEMENT OF RESPONSIBILITY**

Name of Participant: \_\_\_\_\_

By signing this form, I acknowledge that all of the information provided on the *Participant's Medical History* form is accurate to best of my knowledge. Please provide your physician's name and phone number for our records.

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Physician's Phone: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_