

2022 Membership Application & Medical Release  
Greek Peak Adaptive Snowsports

Fee for participant with a disability: \$50 per day

Season Pass for participant with a disability: \$385

Please make checks payable to: Greek Peak Adaptive Snowsports (GPAS)

**Part 1: Participant Information**

Name \_\_\_\_\_ DOB \_\_\_\_\_ Years as a member \_\_\_\_\_

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

County of Residence \_\_\_\_\_ Phone (home) \_\_\_\_\_ (cell) \_\_\_\_\_

Email \_\_\_\_\_

Contact person for emergencies \_\_\_\_\_  
Phone \_\_\_\_\_

Skiing/Riding Ability       New       Beginner       Novice       Intermediate

Disability(ies): *(check all that apply)*

- |  |   |   |
|--|---|---|
| <input type="radio"/> Amputation                   | <input type="radio"/> Autism              | <input type="radio"/> Cerebral Palsy        |
| <input type="radio"/> Diabetes                     | <input type="radio"/> Epilepsy            | <input type="radio"/> Hearing Impairment    |
| <input type="radio"/> Intellectual Disability (MR) | <input type="radio"/> Learning Disability | <input type="radio"/> Spinal Cord Injury    |
| <input type="radio"/> Traumatic Brain Injury (TBI) | <input type="radio"/> Vision Impairment   | <input type="radio"/> Other (specify) _____ |

Please list any medications or additional medical conditions:

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

Please list any additional information that will help our coaches be more effective (i.e. favorites, dislikes, triggers)

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

**Part 2: Participant Certification**

If the participant is an adult who is not subject to a guardianship, he or she may sign this application on his or her own behalf. If the participant is a minor under the age of 18, this application must be signed by one of the applicant's parents or a legal guardian. If the applicant is an adult subject to a guardianship, this applicant must be signed by the applicant's legal guardian. The person signing this form must certify one of the following (check whichever box is applicable):

\_\_\_\_\_ I am an adult eighteen years of age or older and am not subject to any guardianship.

\_\_\_\_\_ The applicant is a minor under the age of 18 and I am the applicant's parent or legal guardian.

\_\_\_\_\_ The applicant is an adult over the age of 18 and I am the applicant's legal guardian.

Name of Parent or Legal Guardian: \_\_\_\_\_

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Address of Parent or Legal Guardian: \_\_\_\_\_

**Part 3: Health History**

*To be completed by applicant, parent, or legal guardian*

- |                       |                       |  |                       |                       |  |
|-----------------------|-----------------------|--|-----------------------|-----------------------|--|
| Yes                   | No                    |  | Yes                   | No                    |  |
| <input type="radio"/> | <input type="radio"/> | Heart Disease / Heart Defect / High Blood Pressure | <input type="radio"/> | <input type="radio"/> | Allergy _____                              |
| <input type="radio"/> | <input type="radio"/> | Chest Pain   | <input type="radio"/> | <input type="radio"/> | Medicines _____                            |
| <input type="radio"/> | <input type="radio"/> | Seizures   | <input type="radio"/> | <input type="radio"/> | Insect Stings / Bites _____                |
| <input type="radio"/> | <input type="radio"/> | Diabetes   | <input type="radio"/> | <input type="radio"/> | Special Diet _____                         |
| <input type="radio"/> | <input type="radio"/> | Concussion / Serious Head Injury                   | <input type="radio"/> | <input type="radio"/> | Asthma _____                               |
| <input type="radio"/> | <input type="radio"/> | Heat Stroke / Exhaustion                           | <input type="radio"/> | <input type="radio"/> | Tobacco Use _____                          |
| <input type="radio"/> | <input type="radio"/> | Blindness / Visual Problem                         | <input type="radio"/> | <input type="radio"/> | Easy Bleeding _____                        |
| <input type="radio"/> | <input type="radio"/> | Contact Lenses / Glasses                           | <input type="radio"/> | <input type="radio"/> | Emotional / Psychiatric / Behavioral _____ |
| <input type="radio"/> | <input type="radio"/> | Hearing Loss / Hearing Aid                         | <input type="radio"/> | <input type="radio"/> | Sickle Cell Trait or Disease _____         |
| <input type="radio"/> | <input type="radio"/> | Bone or Joint Problem                              | <input type="radio"/> | <input type="radio"/> | Immunizations Up to Date _____             |
|                       |                       |  | <input type="radio"/> |                       | Other (specify) _____                      |

Date of most recent tetanus immunization \_\_\_\_/\_\_\_\_/\_\_\_\_

If you have Down's syndrome, GPAS requires an x-ray for atlanto-axial instability. Negative \_\_\_\_\_  
X-ray taken \_\_Yes \_\_\_No Results: Positive \_\_\_\_\_

Signature of Parent/Guardian/Caregiver or Adult Athlete \_\_\_\_\_ Date \_\_\_\_\_

**Part 4: Medical Release**

*To be completed by medical provider for participants that DO NOT have a current Medical release form on file with Special Olympics*

Blood Pressure \_\_\_\_/\_\_\_\_ Weight \_\_\_\_ Height \_\_\_\_

- |                       |                       |                       |                       |                       |              |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|--------------|
| Normal                | Abnormal              |                       | Normal                | Abnormal              |              |
| <input type="radio"/> | <input type="radio"/> | Vision                | <input type="radio"/> | <input type="radio"/> | Skin         |
| <input type="radio"/> | <input type="radio"/> | Hearing               | <input type="radio"/> | <input type="radio"/> | Neck         |
| <input type="radio"/> | <input type="radio"/> | Reflexes              | <input type="radio"/> | <input type="radio"/> | Coordination |
| <input type="radio"/> | <input type="radio"/> | Cardiovascular System | <input type="radio"/> | <input type="radio"/> | Extremities  |
| <input type="radio"/> | <input type="radio"/> | Respiratory System    |                       |                       |              |

Other \_\_\_\_\_ Primary MR Etiology/Category (if known): \_\_\_\_\_

I have reviewed the above health information and have performed an examination on this participant within the past six months and certify that he/she can participate in snowsports activities with Greek Peak Adaptive Snowsports.

Examiner's Signature \_\_\_\_\_

Date \_\_\_\_\_

Examiner's Name \_\_\_\_\_

MD License # \_\_\_\_\_

Address \_\_\_\_\_