



Intake Form

A 501(c)3 nonprofit organization

Today's Event:

Date:

One Form Per Person - Please Fill out Form Completely and Print Clearly

Participation Category	Please check all that apply: <input type="checkbox"/> Participant with a disability <input type="checkbox"/> Active Military <input type="checkbox"/> Veteran <input type="checkbox"/> Wounded Warrior Project Alumni <input type="checkbox"/> WWP Alumni Caregiver/ Family Member Name of Warrior: _____		<input type="checkbox"/> Parent / Guardian <input type="checkbox"/> Caregiver <input type="checkbox"/> Family Member <input type="checkbox"/> Friend Name of associated participant: _____			
	Please check one: <input type="checkbox"/> Youth (Ages 6-17) <input type="checkbox"/> Adult (Ages 18+)		<input type="checkbox"/> Volunteer <input type="checkbox"/> Community Member			
Contact Information Home of Record	First Name		Last Name		Gender M F	Date of Birth / /
	Mailing Address (Street/Home of Record) ***DO NOT use Institutional Address***					Apt or Suite
	City			State		Zip
	Home Phone			Mobile Phone		
	Email(s)					
Emergency Contact	First Name		Last Name		Relationship	
	Primary Phone (Best Contact #)			Email		
Personal Information	Please describe any ALLERGIES you have: (Medication, Food, or Environmental)					
	Please list all MEDICATIONS you currently take:					
	Do you have a history of seizures?					
	Date of last seizure: / /					
	Do you have a history of diabetes? How is your condition controlled?					

Please fill out the back side of this form and complete attached waiver.

	Height:	Weight:	Shoe Size:	T-shirt Size: (please denote youth, men's or women's)
	Do you have a service animal? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of service animal: _____	
Disability Information	Disability Information (please check all that apply)			
	<input type="checkbox"/> Spinal Cord Injury Location: _____ <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> PTSD <input type="checkbox"/> TBI <input type="checkbox"/> Stroke <input type="checkbox"/> Visual Impairment Please Circle: Total or Partial	<input type="checkbox"/> Above Knee Amputee <input type="checkbox"/> Below Knee Amputee <input type="checkbox"/> Arm Amputee <input type="checkbox"/> Multiple Amputee <input type="checkbox"/> Hearing Impairment Please Circle: Total or Partial	<input type="checkbox"/> Other: (please list)
	Mobility / Assistive Devices (please check all that apply)			
	<input type="checkbox"/> Ambulatory <input type="checkbox"/> Manual Wheelchair (please circle: FT or PT) <input type="checkbox"/> Power Wheelchair (please circle: FT or PT)	<input type="checkbox"/> Crutches / Walker/ Cane <input type="checkbox"/> AFO / Leg Braces <input type="checkbox"/> Prosthetics	<input type="checkbox"/> Other:	
Program Interest	Programs of Interest (please check all that apply)			
	<input type="checkbox"/> Climbing <input type="checkbox"/> Cross-Country Skiing <input type="checkbox"/> Cycling <input type="checkbox"/> Downhill Skiing <input type="checkbox"/> Dragon Boat	<input type="checkbox"/> Kayaking/Paddleboarding <input type="checkbox"/> Rafting <input type="checkbox"/> Sailing <input type="checkbox"/> SCUBA <input type="checkbox"/> Water-skiing/Wakeboarding	<input type="checkbox"/> Other: <input type="checkbox"/> Office/Admin <input type="checkbox"/> Fundraising <input type="checkbox"/> Special Events	
Military Only	Branch of Service		Rank	
	Date of Injury / /		Combat Related? (Please Circle) Yes No Service Related? (Please Circle) Yes No	
	Required Are you eligible to participate in VA programs and not debarred? <input type="checkbox"/> Yes, I'm eligible <input type="checkbox"/> No, I'm not	Have you served post 9/11? <input type="checkbox"/> Yes <input type="checkbox"/> No	What is your home VA? _____	
Volunteer/Participation Information	Occupation (please check all that apply)			
	<input type="checkbox"/> Employed Part-time <input type="checkbox"/> Employed Full-time <input type="checkbox"/> Retired	<input type="checkbox"/> Student (Under 21 years old) <input type="checkbox"/> Student (Over 21 years old) <input type="checkbox"/> Unemployed		
	What is your occupation?	Please list applicable trainings, skills and volunteer experience:		
	Have you completed first aid training? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you have a driver's license? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Optional Information	Ethnicity: (please check one of the following) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		Race: (please check all that apply) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other	
	Adaptive Adventures strives to provide free programming at all levels, however, in some instances camp, travel, and clinic fees do apply. Do you feel you would qualify for financial assistance if the need arises? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Participation in Adaptive Adventures programs is subject to review and evaluation by Adaptive Adventures staff. Modified 2/6/2015