

BADGERLAND VETERAN'S ADAPTIVE SPORTS CLINIC VETERAN REGISTRATION FORM

PLEASE RETURN FORMS TO JOYCE CASEY, EXT 41256 or Chelsea Kindler, EXT 41258

SPINAL CORD INJURY RECREATION THERAPISTS

FAX: 414-382-5293



REGISTRATION FORMS ARE DUE NO LATER THAN Sept. 26, 2016

REGISTRATION IS LIMITED
SCI VETERANS WILL HAVE PRIORITY

VETERAN'S NAME: _____ PHONE: _____ EMAIL: _____

PRIMARY VA CLINIC: _____ DATE OF BIRTH: _____

CYCLING EXPERIENCE:

- BEGINNER
- INTERMEDIATE
- ADVANCED

Types of cycles tried: _____

- Cycle interested in trialing: _____
- Wheelchair wash 1-3pm ___yes ___no, thanks!

- YES: if yes, type: _____
- NO

MEDICAL CLEARANCE:

PRIMARY DIAGNOSIS:

- Paraplegic
- Quadriplegic
- Multiple Sclerosis
- TBI/Polytrauma
- Amputee
- PTSD
- Low Vision
- Other

LEVEL OF INDEPENDENCE:

- Independent
- Independent once oriented
- Need sighted guide
- Need assistance with mobility
- Need assistance with transfers

LIMITATIONS/PRECAUTIONS:

MEDICAL HISTORY:

- Allergies: _____
- Heart Problems
- Diabetes
- High Blood Pressure
- Back Problems
- Seizures
- Current Medication: _____

- Other (please specify) _____

MOBILITY:

- Ambulatory
- Ambulatory with assistive device (cane, walker)
- Manual Wheelchair (assistance _____)
- Power Wheelchair (assistance _____)

EMERGENCY CONTACT INFORMATION:

NAME: _____ RELATIONSHIP: _____

PHONE NUMBER: _____

For logistical questions, coll Joyce (ext. 41256) or Chelsea (ext. 41258), For medical questions, contact Dr. Ken Lee (ext. 41288)

BRINGING OWN CYCLE: This veteran is medically cleared to participate in cycling clinic

PHYSICIAN'S SIGNATURE: _____ DATE: _____