



NATIONAL
ABILITY
CENTER

**Participant
Information**

The thorough and accurate completion of this form is mandatory for you to participate in our programs. Our focus is to provide a safe and fun environment for all programs, and the facts you disclose will be confidential. This information will better prepare our staff to serve you, and respond professionally in the unlikely event of an emergency or illness. **Please complete this form and return it to the NAC, P.O. Box 682799 Park City, Utah 84068 or via fax to #(435)-658-3992. Thank You.**

Date: _____ **EMAIL :** _____ Program Attending: _____
Name: _____ Birth Date: _____ Ht. ____ Wt. ____ Sex: M F
Address: _____
City/State: _____ Zip: _____
Parent/Guardian/Contact (if under 18): _____
Phone: Home: _____ Work / Cell: _____
Emergency Contact: _____ Phone: _____
Disability: _____

PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT YOUR PHYSICAL HEALTH
Activities may be strenuous, either physically and/or mentally, please make information as detailed as possible.

How would you describe your lifestyle? (Sedentary, routine exercise, athlete, etc.):

What activities does this include? _____

What two things would you like to accomplish by participating with us? (Be specific)

1. _____

2. _____

Fears or phobias: _____

(PLEASE COMPLETE REVERSE SIDE)

Are you currently under any medical treatment for a disease or condition? Yes ___ No ___

If YES Please explain: _____

Are you currently taking any medication? Yes ___ No ___

If yes, please give the name, dosage, frequency and side effects?

Do you have any allergies, including foods, animals, medications, bites or stings?

Yes ___ No ___ If yes please list _____

Do you have any physical limitations? Yes ___ No ___ If yes circle all that apply:

Balance Muscle tone Neck Spine Arms Hands Hips Knees Ankles/Feet

Detailed explanation: _____

Do you require a mobility assistance device? Yes ___ No ___ If yes circle all that apply:

Wheelchair Walker Crutches Braces Cane Prosthesis Other

Detailed explanation: _____

Do you have any sensory limitations? Yes ___ No ___ If yes circle all that apply:

Sight Hearing Speech Touch Hyper-sensation Hypo-sensation Other

Detailed explanation: _____

Do you have any cognitive limitations? Yes ___ No ___ If yes circle all that apply:

DD Dyslexia Fear Literacy Processing delay Aphasia ADHD/ADD Other

Detailed explanation: _____

Do you have any other medical limitations? Yes ___ No ___ If yes circle all that apply:

Diabetic Pregnant Seizure disorder Heart condition High blood pressure Other

Detailed explanation: _____

I understand that the information I have provided on this form is required in order to be a participant in this program. I acknowledge that this information is current, complete and accurate and there is nothing I have omitted. I give permission to the NAC staff to call for emergency medical treatment if it becomes necessary.

SIGNATURE OF PARTICIPANT _____ DATE _____

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____
(IF UNDER THE AGE OF 18)