ACCESS ADVENTURE

Challenging the Limits of Disability

P. O Box 2852
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707-432-0152
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Student Application and Health History

GENERAL INFORMATION

Student: ______________________________

DOB: ____________ Age: ______ Height: ______ Weight: ______ Male ______ Female ______

Address: ______________________________

Phone: ______________ Alternative Phone: ______________

Parent/Legal Guardian: ______________________________

Address (if different from above): ______________________________

Phone: ______________________________

Referral Source: ______________________________

How did you hear about our program? ______________________________

HEALTH HISTORY

Please indicate current or past problems in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

What medications is student currently taking, including over-the-counter medications?

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Describe student's abilities/difficulties in the following areas (include assistance required or equipment needed)

FUNCTION (i.e. mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

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SOCIAL (i.e. work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.

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GOALS (i.e. why you are applying for participation and what you would like to accomplish):

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PHOTO RELEASE

I ___ DO

___ DO NOT

Consent to and authorize the use and reproduction by Access Adventure of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: ______________________________ Date: ____________

Student, Parent, or Legal Guardian