

## 2010 Quantum LEAP Recreational Optional Form

Name \_\_\_\_\_ Age: \_\_\_\_\_ Gender: Male Female

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

HomePhone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

*Please check the following that applies to you and/or write in any other special situation we should be aware of:*

- |   |   |
|---|---|
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Downs Syndrome           |
| <input type="checkbox"/> Mental Illness       | <input type="checkbox"/> Vision Impaired          |
| <input type="checkbox"/> Head Injury          | <input type="checkbox"/> Developmental Disability |
| <input type="checkbox"/> Autism               | <input type="checkbox"/> Cerebral Palsy           |
| <input type="checkbox"/> Multiple Sclerosis   | <input type="checkbox"/> Hearing Impaired         |
| <input type="checkbox"/> Seizures             | <input type="checkbox"/> Learning Disability      |
| <input type="checkbox"/> Spinal Cord Injury   | <input type="checkbox"/> Spina Bifida             |
| <input type="checkbox"/> Muscular Dystrophy   | <input type="checkbox"/> Balance Problems         |
| <input type="checkbox"/> Fainting Spells      | <input type="checkbox"/> Emotional Disability     |
| <input type="checkbox"/> Allergies (any type) | <input type="checkbox"/> Diabetes                 |
| <input type="checkbox"/> Stroke               | <input type="checkbox"/> Heart Disease/defect     |
| <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Back Problems            |
| <input type="checkbox"/> Other                |   |

If you answered yes to any of the above, please describe more fully here:

\_\_\_\_\_  
Are you taking any medications? Please list and describe what they are for and if you experience any side effects that we should be aware of:

\_\_\_\_\_  
Do you know of any behavioral or health factors that make it advisable for you to follow a limited program of physical activity or to refrain from participating in any of the program activities? If yes, please explain. Mention any recent surgery, illness, broken bones, injuries, allergies, or other physical conditions.

\_\_\_\_\_  
I use one of the following to get around:  Manual Wheelchair  Crutches  Other  Scooter  
 Power Wheelchair

Do you use any alternative methods for communication? \_\_\_\_\_ If yes, please explain:

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