



2012 OPTIONAL INFORMATION FORM

Participants must be 18 years of age or older.

Name _____ Age _____ Gender Male Female

Address _____

City _____ State _____ Zip Code _____

Telephone Home _____ Work _____ Cell _____

E-Mail Address _____

Agency Contact's Name _____ Telephone _____

Title House Manager Team Leader Program Supervisor Other _____

Check any of the following that apply and/or write in other special situations of which we should be aware.

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

Are you taking any medications? Yes No

If yes, for each medication please list name, what you take it for, and any side effects of which we should be aware.

Are there 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? Yes No

If yes, please explain. Include information about any recent surgeries, illnesses, broken bones, injuries, allergies, or other physical conditions.

Check if you use: Manual Wheelchair Power Wheelchair Scooter Crutches Other

Do you use any alternative methods for communication? Yes No

If yes, please explain below.

