



**SportsNet**  
**Shared Ski Adventures**  
 Student Application Form  
[www.sharedskiadventures.org](http://www.sharedskiadventures.org)



*2024 Ski Season*  
*January 13<sup>th</sup> – March 2<sup>nd</sup>*

**Please complete all sections of this Application Form and do not leave any blanks.**

**\*This form includes a Medical Information section (pages 3 & 4) and it must be signed by your physician.\***

- **Return printed form to:** CP Rochester/ 3399 Winton Road South / Rochester, NY 14623 / Attn: SSA
- **or email form (scanned with physician’s signature) to:** [jmiller@cprochester.org](mailto:jmiller@cprochester.org)

Participant Information					
<i>Name:</i>		<input type="checkbox"/> <i>Male</i>	<input type="checkbox"/> <i>Female</i>	<i>DOB:</i>	
		<input type="checkbox"/> <i>Prefer not to specify</i>			
<i>Current Address:</i>	<i>Street:</i>				
	<i>City:</i>	<i>State:</i>		<i>Zip:</i>	
<i>Phone:</i>		<i>Email (required):</i>			
<i>Insurance #:</i>		<i>Ins. Provider:</i>			
<i>Other Insurance:</i>					
In case of emergency, the following person(s) are to be called:					
<i>Contact 1:</i>		<i>Cell Phone:</i>			
<i>Relationship:</i>	<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other:				
<i>Contact 2:</i>		<i>Cell Phone:</i>			
<i>Relationship:</i>	<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other:				

Primary Health Care Provider					
<i>Policy Holder:</i>		<i>Policy #:</i>			
<i>Primary Physician:</i>					
<i>Address:</i>	<i>Street:</i>				
	<i>City:</i>	<i>State:</i>		<i>Zip:</i>	
<i>Phone:</i>		<i>Fax:</i>			
<i>Hospital Affiliation:</i>					

Medicaid Care Manager Information (if applicable, please complete)	
<i>MSC Name:</i>	
<i>Agency Affiliation:</i>	
<i>Phone Number:</i>	

Communication			
Primary Language		Secondary Language	
	English		English
	Spanish		Spanish
	American Sign Language		American Sign Language
	Symbolic / Type =		Symbolic / Type =
	Communication device / Type =		Communication device / Type =
	Non-verbal		Non-verbal
	Other:		Other:
Comprehension			
	Understands verbal directions		Understands Sign Language
	Understands 2-3 step verbal directions		Uses PECS to communicate best
	Understands 1-step verbal directions		Other: (please describe below)

Self-awareness / Safety <i>Parents/Guardians: Please check the situations that participant may need assistance with.</i>			
	Wandering away from instructors		Navigating the parking lot
	Being aware of self in relation to others skiers on the hill		Comprehending the ski hill in terms of staying on the trail
	Other (describe):		
Is the participant susceptible to the cold?		<input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>How</b> can participant communicate to an instructor that they feel cold?			
<b>How</b> can participant communicate if something hurts/is painful?			

Recreation Interests - <i>Please take the time to complete this section – it is very helpful for our instructors!</i>	
Please list your recreation interests, hobbies or other helpful things for our instructors to know.	
LIKES (music, books, sports, favorite color, etc)	DISLIKES

Medical Information									
<b>Health history</b> <i>Please check any of the following conditions that you presently have or have had in the past:</i>									
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Swelling of hands	<input type="checkbox"/>	Skin breakdown	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	Swelling of feet	<input type="checkbox"/>	Latex allergy	<input type="checkbox"/>	Fainting spells
<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	UTIs	<input type="checkbox"/>	Swelling of ankles	<input type="checkbox"/>	Latex sensitivity	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Stomach problems	<input type="checkbox"/>	Head injury
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Extreme Fatigue	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	Swallowing problems
<b>Do you have any of the following directives?</b>									
<input type="checkbox"/>	Do-Not-Resuscitate	<input type="checkbox"/>	Living will	<input type="checkbox"/>	Health Care Proxy				

<b>Physical</b>			
<i>Primary Diagnosis:</i>		<i>Secondary Diagnosis:</i>	
<i>Height:</i>		<i>Weight:</i>	
Do you walk independently? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<i>If no, please indicate what kind of mobility aid is used:</i>			
<input type="checkbox"/>	Crutches	<input type="checkbox"/>	Walker
<input type="checkbox"/>	Power wheelchair	<input type="checkbox"/>	Other:
<input type="checkbox"/>		<input type="checkbox"/>	Manual wheelchair

<b>Vision</b>
Do you wear glasses, corrective lenses or use other visual aids? <input type="checkbox"/> No <input type="checkbox"/> Yes
<i>If yes, please describe the degree of visual disability:</i>

<b>Hearing</b>
Do you use any hearing or communication aids? <input type="checkbox"/> No <input type="checkbox"/> Yes
<i>If yes, please describe degree of hearing disability:</i>

<b>Allergies</b> <i>Please list any known allergies, including medications, food...</i>
<b>If you have allergies,</b> please indicate the type of reaction/symptoms you typically experience:
<b>Do you carry an EpiPen?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes

<b>Medical restrictions to diet</b> (diabetic, gluten free, low calorie...) <i>*there are usually cookies &amp; treats in the Cocoa Hut so this is particularly important for instructors to be aware of!</i>

Seizure History	
Have you ever had a seizure?	<input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, please answer the following questions:</i>
Please describe as fully as possible, a typical seizure episode, including physical characteristics, and duration. Describe any warning signs that a seizure is about to occur: *SSA can provide chair lift belts for individuals for safety*	

Medications <i>Please list all current medications:</i>	
Medication	Purpose

Does the applicant demonstrate any of the following behaviors? <i>(If yes, please indicate frequency.)</i>					
Behavior	NO	YES	DAILY	WEEKLY	MONTHLY
Physical Aggression					
Wandering/Running Away					
Destroys Property					
Tantrums					
Self Injurious Behavior					
Verbal Outbursts					
Mouthing/Swallowing or eating non-food items					
Interactions with others that are not appropriate					
Other:					

**PERSONAL CARE**

A caregiver must be on-site, within visual range of base of the mountain, and available to provide personal care if needed.

**HELMET POLICY**

All SSA students and instructors **must** wear a helmet for the duration of the program. It must be strapped on and fit correctly. **SSA does not provide helmets;** Helmets must be provided by the individual or rented from SWAIN for a fee

**PERSONAL EQUIPMENT USE DECLARATION (\*IF APPLICABLE, PLEASE SIGN\*)**

I have chosen to utilize the following **personal equipment** while participating in CP Rochester’s Shared Ski Adventures program (circle all that apply): Skis/Snowboard/Sit Ski      Helmet      Outriggers

Other: \_\_\_\_\_

I do hereby agree that I wish to use the above personal equipment while participating in CP Rochester’s Shared Ski Program. I understand that the equipment must only be used for its intended purpose and any other use is strictly forbidden. SportsNet assumes no liability for negligence of the parties or any manufacturer defects. I do hereby agree to ensure that the equipment is in proper working condition while participating in CP Rochester’s Shared Ski Program.

Participant/Guardian signature      date

**\*\*If you will not be using any of your own equipment please move on to next section of application\*\***

Person Completing Form (print name):			
Person Completing Form (Signature):		Date:	
Relationship to Applicant (If Applicable):			
Physician Signature (required):		Date:	

**PARTICIPATION PREFERENCE FORM**

**The number of students we can enroll in the program is dependent upon instructor and equipment availability. There will be a limited number of spots for students. Keeping this in mind, the earlier you send in your registration form, the more likely a lesson spot will be available.**

- Once the application is received we will send confirmation of enrollment along with any questions we may have and how many weeks are available depending on instructor and equipment availability.
  - Then, after the new year if payment is not submitted with the registration form a PayPal invoice will be sent via e-mail once registration has been confirmed. You may pay online via PayPal or by sending cash/check to Shared Ski Adventures, payment must be received before the start of program
  - Lesson spot will be confirmed only after payment is received
- If you received OPWDD Services and plan on applying for Family Reimbursement please check here**

<b>Please select your preference for the 2024 season and we will do our best to accommodate it. If your preference is not available, we will contact you upon receiving your application</b>			
	<b>4 lessons – 1<sup>st</sup> 4 weeks - \$280.00</b>		<b>4 lesson – 2<sup>nd</sup> 4 weeks - \$280.00</b>
<b>9:30am – 12:30am Lesson Time</b>			

\*\*\*\*\*8 week lessons may be available, please indicate to Shared Ski Adventures if you are interested in an 8 week session and if there is open availability in either session after registration is closed you will be contacted. Please understand this is not guaranteed and spots will be filled based on order registrations are received and equipment availability (first come, first serve)\*\*\*\*\*

**CANCELLATION POLICY**

Shared Ski Adventures reserves the right to cancel a ski lesson in the event of conditions that would impact the safety of our participants (for example: not enough snow, high wind advisories, more ice than snow, etc.).

**We do not offer refunds for either cancelled or missed days.** Skiing is a weather-dependent sport!

OFFICE USE ONLY								
	New Student	<b>Payment Information</b>	PayPal		Trans. ID:			
	Returning student		Check		Check #:		Date Rec'd:	
			Cash					