Overcoming Barriers Program

Mentee Name: _____ Program: _____

Personal and Medical Information Request

Please complete this form in its entirety. The information requested will be kept in strict confidence and will only be used in preparing the most appropriate physical activity program for this Mentee. Please check off the appropriate program that the person will be attending.

Participant's Name _____ **D.O.B.**_____

Address/Group Home _____

Contact Person and Telephone Number _____

Contact Person's Cell Phone _____

Contact Person's E-mail _____

Participant's Disability (ies)* Please check all that apply:

_____ **Amputation-**Which limb is affected and where?
_____
_____ **Autism Spectrum Disorders** Type_____
_____ **Blind/Visual Impairment**
_____ **Cerebral Palsy**
_____ Ataxia *Limbs Involved _____
_____ Athetoid _____
_____ Spastic
_____ **Deafness/Hard of Hearing**
_____ **Emotional Disorder**
*If yes, please describe particular behavior(s)
_____
_____ **Intellectual Disability (Mental Retardation)** *If the participant has Down syndrome, please indicate whether or not this person has been screened and cleared of Atlanto-Axial Instability- Yes _____No _____ Date of X-Ray _____
_____ **Learning Disabilities** (Can include Dyslexia, ADD, ADHD, etc.) **DO NOT check if person has an intellectual disability checked above!**
_____ **Muscular Dystrophy**
_____ **Orthopedic Impairments**
_____ **Spina Bifida** Type and/or Level_____
_____ **Spinal Cord Injury** *Level of Injury _____
_____ **Stroke/Traumatic Brain Injury**
_____ **Other**

Overcoming Barriers Program

Mentee Name: _____ Program: _____

Restrictions Due to Medical and/or Physical Conditions **Current BP _____/_____**

_____ **Asthma** _____ **Arthritis** _____ **Diabetes**
_____ **Heart Disease** _____ **Hip Dislocation** _____ **Osteoporosis**
_____ **Overweight/Obese** _____ **Posture** _____ **Spinal Rod**
_____ **High Blood Pressure** _____ **Other Not Listed**_____
_____ **Seizures** *If yes, please describe the type of seizure **and** last documented activity along with procedures for assisting this person

_____

_____

Provide details about any restrictions checked on the first page

_____

_____

Any Additional Behavioral Concerns

_____

_____

Medication(s) if needed during programming _____
_____

Time and Who Will Administer _____

Please check the most appropriate description for the following categories:

This Participant:
_____**Is ambulatory**
_____**Uses a cane, crutches, or a walker**
_____**Uses a manual wheelchair independently**
_____**Use a manual wheelchair with assistance**
_____**Uses an electric wheelchair**

Participant Will Participate:
_____ **Land Only**
_____ **Water Only**
_____ **Both-Alternating**

Dressing Skills:
_____**Independent**
_____**Minimal assistance***

Overcoming Barriers Program

Mentee Name: _____ Program: _____

***Explain_____**
_____Total assistance

Level of Activity Recommended: **_____ Mild**
_____ Moderate
_____ Vigorous

Additional Comments:

_____

_____

_____

Please return this complete form to:

Thomas E. Moran, Ph.D., CAPE
Assistant Professor, PHETE Program
Department of Kinesiology
James Madison University
261 Bluestone Drive, MSC 2302
Harrisonburg, VA 22807

Phone: 540-568-4877

Fax: 540-568-3338

E-mail: morante@jmu.edu