ADDS MEMBERSHIP APPLICATION:
CONFIDENTIAL MEDICAL QUESTIONNAIRE

Name: _____ OHIP #:_____
Address: _____
City: _____ Postal Code:_____
Tel #: _____ E-Mail_____
Date of Birth: _____
(mm/dd/yyyy)

Person(s) to call in case of emergency:
Name:_____ Tel #:_____
Name:_____ Tel #:_____

Family Doctor:_____ Tel #:_____
Address: _____ City: _____ Postal Code: _____

I. MEDICAL INFORMATION:

Mark all medical conditions that apply to applicant with an "X", and add details as indicated:

❒ Amputations:
❒Hand ❒Left ❒Right
❒Arm ❒Left ❒Right ❒Below Elbow ❒Above Elbow
❒Leg ❒Left ❒Right ❒Below Knee ❒Above Knee
❒Ski with Prosthesis ❒Ski without Prosthesis

❒ Closed head injury
❒ Hemi-paresis/paralysis ❒ Arm ❒ Leg ❒Trunk ❒ Left ❒ Right
❒ Paraplegia / Quadriplegia Level of lesion:_____
❒ Sensory Loss: ❒ Touch ❒ Pain ❒ Hot ❒ Cold ❒ Kinesthetic
Location:_____
❒ Seizure Disorder: Frequency:_____ Seizure precipitant(s):_____
❒ Visual Deficit/Description:_____
❒ Fragile Bones
❒ Bruise Easily
❒ Cardiac Problem – Describe:
_____
❒ Diabetes
❒ High Blood Pressure ❒ Low Blood Pressure
❒ Sensori-motor Problem-- Describe:_____
❒ Cerebral Palsy-- Describe motor problems:_____
❒ Inco-ordination of ❒ Arms ❒ Legs ❒ Trunk
❒ Impaired mobility—Mobility Aids Used: ❒ Cane(s) ❒ Crutches ❒ Walker
❒ Wheelchair ❒ Scooter ❒ Other:_____
❒ Cognitive / Communication Problem—Describe:_____
❒ Other Disabilities / medical conditions -- Describe:_____
_____
_____

ADDS' Applicant's Name: _____

❒ **Medication:** List all medications taken and possible side-effects to watch for:

Medications:	Side Effects:

II. ACTIVITIES OF DAILY LIVING:

Mark all functional problems that apply to applicant with an "X" , and add details as indicated:

❒ Dressing: Need help with:

_____

❒ Toileting: Need help with: _____
❒ Feeding self: Need help with: _____
❒ Topographical Orientation: Need help with: _____
❒ Other:_____

III.COGNITIVE, BEHAVIOURAL, AND PSYCHO-SOCIAL SKILLS:

Mark all functional problems that apply to applicant with an "X", and add details as indicated:

❒ Ability to communicate needs
❒ Sexual disinhibition / inappropriate behavior: _____
❒ Anger control problem
❒ Aggression
❒ Short-term Memory problem
❒ Taking / Borrowing without asking
❒ Other:_____

IV. FOR ALL NEW MEMBERS AND/OR AS REQUESTED BY ADDS' DIRECTORS:

1. To be completed by the applicant's Health Practitioner:

I certify that _____ , born_____, is medically fit to participate in the sport of disabled skiing, as per the below:

❑ Without extraordinary precautions
❑ With precautions: _____

Health Practitioner's Name/address (print clearly): _____

_____

Credentials: _____ Tel #: _____

Health Practitioner's Signature: _____ Date: _____

2. **Skier Assessment** – to be completed by an ADDS-associated occupational or physiotherapist, or other approved health practitioner, prior to acceptance of application. This assessment is only to determine strengths and weaknesses to assist in determining ski equipment and support needs, and ADDS' ability to meet these needs. It does not replace a medical release, and does not guarantee acceptance into ADDS.

I certify that the above information is correct.

Print Name: _____ Signature: _____ Date: _____

Please Return to "ADDS Membership" c/o Brad Ko, a minimum of 1 week before your first planned ski day:
Via Email to: ski.adds@disabledskiingontario.com or brad.ko@gmail.com