15th National Disabled Veterans Winter Sports Clinic

Attention - Read This!

You must completely and correctly fill out the enclosed packet,
or your application **will not** be processed!
Registration Deadline is November 30, 2000. A $50 late fee will be charged to any application received between November 30, 2000 through December 15, 2000.
Applications postmarked after December 15, 2000 will not be accepted!

Two and three-part forms must be placed on a hard surface with nothing under them when you fill them out.

Please do not fold or staple application.

Check Off List

You must include the following forms:

❑ 1. Registration Application (filled out by participant)

❑ 2. General Medical/Physical Exam Form (must be filled out completely and **signed by examining clinician.**)

❑ 3. General Ski information/Alternate Activities (filled out by participant)

❑ 4. Coach Application (filled out by coach, **if you are not a coach, please do not fill out this form.)**

❑ 5. 10-10 Application (filled out by participant) **If you attended in 2000, a DD214 is not necessary**

❑ 6. Home Town News Release Questionnaire (If you want publicity in your home town, **fill this form out!**)

❄ ❄ ❄ ❄ ❄

Please allow 4 weeks for your application to be processed. When accepted, you will receive information regarding hotel reservations and ground transportation.

To avoid confusion and possible loss of funds, please do not make any travel or lodging reservations until you have received the letter notifying you that your application has been accepted.

2001 National Veterans Winter Sports Clinic - Registration Application
Deadline: November 30, 2000

Name_____
(Last) (First) (Middle)

Social Security #_____/_____/_____ DOB_____ ❒ Male ❒ Female

Street Address_____

City_____ State_____ Zip_____

Daytime Phone (____)_____Evening Phone (____)_____

E-Mail Address:_____

Name of VAMC at which you receive care:_____

What branch of service were you in?_____ Which Years? 19____To 19____

Service organizations you belong to:_____

_____

Have you competed in an organized disabled sports event? ❑ Yes ❑ No

Have you ever participated in the Winter Sports Clinic? ❑ Yes ❑ No

If you have participated in the Winter Sports Clinic, please specify which years:_____

What is your VA status? ❑ Inpatient ❑ Outpatient

Service Connected? ❑ Yes ❑ No

The National Disabled Veterans Winter Sports Clinic is a VA/DAV co-sponsored event. The clinic is an outreach of the Grand Junction VA Medical Center and VISN 19. Compliance with VA regulations and policies is mandatory at this event for all participants. Bringing weapons, un-prescribed drugs or paraphernalia, unexcused non-participation, exhibiting disruptive or abusive behavior and harassment of others in any form, will not be tolerated and may result in immediate expulsion from this event and will effect future participation.

The Department of Veterans Affairs and the Disabled American Veterans encourage a safe environment for all attendees.These rules exist for the safety of everyone involved in the clinic.

Athlete Signature:_____

Note: Registration Deadline is **November 30, 2000.** There will be a **$50 late fee** for any applications postmarked **December 1, 2000 - December 15, 2000.** Applications postmarked after **December 15, 2000**, will **not be accepted.** Applications which are not completely and correctly filled out will be returned to you. They must be corrected or completed and resubmitted by the November 30, 2000 deadline. **Only applications received by mail will be accepted.** Please do not fold or staple the application

Attention: Novices will receive first priority.

For any questions regarding this application, please call:

Sharon Parks at (970) 248-5590.

General Medical/Physical Exam Form
TO BE COMPLETED BY EXAMING CLINICIAN

Please read carefully before completing all forms in their entirety

Please type or print clearly

Dear Clinician: Your patient is planning on participating in a vigorous outdoor winter sporting event that takes place at high altitude, providing you concur. Please assist us to ensure that candidates are appropriate by conducting a detailed review of your patient's medical record. Examples of high risk patients are: a quadriplegic smoker who is overweight; brittle diabetics, patients with severe COPD; and patients who require close medical supervision.

Patient's Name_____ Date _____

Social Security Number _____/_____/_____ Age_____

Patient's Home Address _____

City, State _____ Zip Code _____

Patient's Daytime Phone (____)_____Evening Phone(____)_____

VAMC where patient receives care:_____

Primary Diagnosis/Type of Injury Date of onset_____/_____/_____

❑ Spinal Cord Injury (SCI) - Level_____ ❑ Complete ❑ Incomplete

❑ Multiple Sclerosis (MS) ❑ Head Injury ❑ CVA with residual_____

❑ Amputee ❑ Right leg, A/K, B,K ❑ Right arm, A/E, B/E ❑ Other_____

❑ Left leg, A/K, B/K ❑ Left arm, A/E, B/E

Visual Impairment Diagnosis:_____

❑ Legally blind (best corrected<20/200 ou.) ❑ Field loss ❑ Totally blind

Which eye(s) affected? ❑ Right ❑ Left ❑ Both

Can patient see with glasses? ❑ No ❑ Yes

Any other Diagnosis?_____

MEDICAL HISTORY Has the patient ever had any of the following? If yes, check boxes that apply.

❑ altitude sickness	❑ asthma	❑ dysreflexia (autonomic)
❑ high altitude pulmonary edema	❑ anticoagulation	❑ diabetes
❑ current psychiatric care	❑ hypoxia requiring O2	❑ COPD
❑ chronic pain requiring narcotics	❑ coronary heart disease	❑ seizures

If yes, please explain:

_____

_____

Other medical information concerning patient's current health status:_____

_____

Is patient allergic to anything? ❑ No ❑ Yes - If yes, specify:_____

Does the patient smoke? ❑ No ❑ Yes

Current medications: (May attach Health Summary that includes current medications) ❑ None

1._____ 4._____

2._____ 5._____

3._____ 6._____

General Medical/Physical Exam Form (page 2)

Patient's Name_____ Social Security Number_____

PHYSICAL EXAM Height_____ (inches) Weight_____ (lbs.) **Weight limit is 220#**

(Note: all participants will be weighed during registration)

Pulse_____ Blood Pressure_____ Heart_____ Lungs_____

Head & Neck _____ Abdomen _____ Extremities _____

Patient requires attendant? ❑ No ❑ Yes If yes, attendants' name_____

Uses wheelchair majority of time? ❑ No ❑ Yes

Uses other adaptive equipment? ❑ No ❑ Yes, if so what?_____

Sitting balance: ❑ Normal ❑ Fair ❑ Poor

In the examining clinician's opinion, the above individual:

❑ **IS** cleared to compete. ❑ **IS NOT** cleared to compete.

Signature of examining clinician _____

Name of examining clinician (please print) _____

Title of examining clinician_____

Address of examining clinician _____

Phone(____)_____

We have made every effort to streamline this form. To save time, please make sure that you double check your information and that this form is filled out completely and signed by the examining physician. If the patient's condition changes subsequent to this exam, please contact Renae Byrd, Grand Junction VAMC, 970-244-1301.

In case of emergency, notify:

Name_____ Phone (____)_____

Address_____

City, State_____ Zip Code_____

Relationship to patient_____

General Ski Information

Have you skied since your injury? ❑ No ❑ Yes

What type of skiing will you do? (Check all that apply)

❑ Standing up ❑ Sitting down

❑ Alpine (downhill) ❑ Nordic (cross country)

❑ Mono Ski ❑ Bi-Ski ❑ Sighted Guide

❑ 2-Track Stand - Up (two regular skis and poles)

❑ 3-Track Stand-Up (one regular ski and two outriggers)

❑ 4-Track Stand-Up (two regular skis and two outriggers)

The Visually Impaired must check one of the additional boxes:

❑ Standing visually impaired ❑ Sitting visually impaired

What level of skier are you?

Alpine (downhill) ❑ Beginner ❑ Intermediate ❑ Advanced

Nordic (cross-country) ❑ Beginner ❑ Intermediate ❑ Advanced

If you ski standing, do you wear leg braces? ❑ No ❑ Yes

If you ski standing, and are planning to cross-country ski, what is your shoe size?

Mens_____ Womens_____

Can you ski independently? ❑ No ❑ Yes

Are you planning on bringing your own ski equipment? ❑ No ❑ Yes

If yes, what type of ski equipment will you bring? _____

_____

All Visually Impaired skiers who can walk will be required to ski standing up. If you are Visually Impaired and can walk, but you wish to ski sitting down, you must be 220 pounds or less. <u>Any sit skier over 220 pounds will not be allowed to ski.</u>

2001 National Veterans Winter Sports Clinic - Coach Application
Deadline: November 30, 2000

A coach will be defined as a person bringing 5 or more participants to the National Disabled Veterans Winter Sports Clinic. In order to have 2 coaches per team, there must be more than 10 participants per team. Once you have been determined as a coach, additional information will be sent to you.

Name_____

(Last) (First) (Middle)

Street Address_____

City, State and Zip_____

Daytime Phone (____)_____Evening Phone (____)_____

VA Medical Center (Representing)_____

Are you planning on attending the 2001 National Disabled Veterans Winter Sports Clinic?

❑ Yes ❑ No

Would you like your team's congratulations letters sent to you? (***These will be sent to you only if they are all sent in by the coach in one packet).***

❑ Yes ❑ No

If you are interested in volunteering at the Winter Sports Clinic, please contact Voluntary Services at 970-244-1336 by January 15, 2001.

List of Team Members Names	***SS#***
1.	
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20.	

2001 National Disabled Veterans Winter Sports Clinic - Registration Application
Home Town News Release Questionnaire

Dear Winter Sports Clinic Participant:
This questionnaire is included as part of the registration packet so that we can prepare a news release to send out to the newspapers back where you live. Because of the growing number of participants, **we**
cannot prepare a news release on your participation in the Clinic if you do not fill out this form completely. We have simplified it as much as possible, so it is very easy to fill out. **If you have any questions, please call Roxanne Fischetti (202) 273-5736.**

1. Your Name: _____

2. **Do you want a news release sent back to the newspaper(s) where you live?**
   ❑ Yes ❑ No

   a. If you answered "No,: ignore questions 2 – 7.

   b. If your answer is "Yes," you **MUST** fill out question 2 – 7. If the form is not **completely** filled out, we cannot produce a news release. The only exception is that first-time skiers do not have to answer #7 (we will ask you after the first time you ski).

3. **What are the nearest daily and weekly newspapers to your home?** (if you don't know the name, please give the closest large city or the county that you live in). _____

   _____

4. **Did you ever serve <u>in combat</u> in any of the following?**

   ❑ World War II ❑ Korea ❑ Vietnam ❑ Bosnia
   ❑ The Gulf War ❑ Other_____

5. **Is your injury/illness <u>Combat related?</u>** ❑ Yes ❑ No

6. Which **general** category does your diagnosis fall under? (Check all that apply)
   ❑ Paraplegic ❑ Amputee ❑ Right leg, A/K, B/K
   ❑ Quadreplegic ❑ Left leg, A/K, B/K
   ❑ Multiple Sclerosis ❑ Right arm, A/E, B/E
   ❑ Neurological damage ❑ Left arm, A/E, B/E
   ❑ Visual impairment ❑ Other_____
   ❑ Stroke
   ❑ Brain Injury

<u>21.</u> Other (please describe in **simple** language, not medical terms): _____

_____

7. **How do you feel about this event?** What has it, and learning to ski done for your life? Why is skiing a good rehabilitation tool? Only those who have skied before must give us a quote at this time. If you have skied before and you do not give us a quote, you will not get a release.