

DREAM Participant



Application

2011-2012



Application Check List

- ___ Personal Information Completed (pg 1)
(parent signature required if under age 18)
- ___ Waiver /Liability Signed (pg 2)
- ___ Medical Information Completed (pg 3)
- ___ Consent for Treatment Signed (pg 4)
(required if under age 18)

For Participants With a School Group

School _____

School Contact Phone _____

School Contact Individual _____

Name _____

Phone _____

Address: Street _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____ Male _____ Female _____

If under age 18

Parent/Guardians' Name _____ Phone _____

Address (If different than above): Street _____ City _____ State _____ Zip _____

___ I DO ___ I DO NOT Give permission for DREAM to pass on the name of my child/ward to
Whitefish Mountain Resort for their marketing database

Signature of Parent or Guardian _____ Date: _____

In Case of EMERGENCY, contact _____ Phone _____

Disability (required for DREAM services) *YOU MUST ALSO FILL OUT THE MEDICAL INFORMATION ON PG 3

- ___ **Neuro Muscular** - specify sub group below
- ___ **Orthopedic** - specify sub group below
- ___ **Cognitive/ Developmental** - specify sub group below
- ___ **Other - specify** _____
- ___ **Vision impaired**
- ___ **Hearing Impaired**

Neuromuscular Sub-Group

Cerebral Palsy
Multiple Sclerosis
Nerve Damage
Post Polio
Post Traumatic Stress Disorder
Spinal Bifida
Spinal Cord Injury
Stroke
Traumatic Brain Injury
Other - specify _____

Orthopedic Sub Group

Amputation
Burns
Dwarfism
Other - specify _____

Cognitive/Developmental Sub Group

Autism
High Functioning/
Asperger's Syndrome
Medium
Low/Severe
Down's Syndrome
Learning Disability
Behavioral Disability
Other - Specify _____

Do you have any other special needs - medical, behavioral, or communicative? _____ if yes, explain:

Participants ON-SNOW EXPERIENCE (skiing level: ___ None, ___ Beginner, ___ Intermediate, ___ Advanced)

Participants EXPERIENCE WITH DREAM: Number of years _____

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Parental Consent/Medical Treatment Form

In the case that an emergency requiring hospitalization and/or surgery develops, minors may not, as a rule, be administered an anesthetic or be operated upon without the written consent of the parent or guardian. Parents or guardians are requested to sign the following statement. **Every effort will be made to contact the parents or guardian before any major treatment. This authorization is to prevent dangerous delay in case an emergency does occur and parents cannot be contacted.**

I, the undersigned parent or guardian of _____, a minor, do hereby authorize adult workers with DREAM Adaptive Recreation Inc. to consent to any examination, x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care which is rendered under supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

Further, as parent or guardian of the minor named above, I do hereby expressly consent that my son/daughter may receive emergency medical treatment from any physician, hospital, or other medical center without the necessity of first notifying me, and do further agree to hold blameless any physician, hospital or other medical center for rendering such services.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnoses, treatment, or hospital care which aforementioned physician in the exercise of his best judgment may deem advisable.

This is my authorization until April 10, 2011, unless an earlier date is specified in writing. _____

(Please print the following information)

Insurance Company or Group: _____

Policy Number: _____

Ongoing prescribed medications: _____

Known allergic reactions: _____

List any medicines/anesthetics to which your son/daughter is allergic. _____

Is there any medical condition, which would have to be taken into account in the event of an emergency? Yes / No. If yes, please explain. _____

Parent or guardian: _____

Day phone: _____ Evening phone: _____ Cell phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Alternate emergency contact: _____

Relationship: _____

Signature of parent or guardian: _____