OPPORTUNITY HOUSE

empowering people with developmental disabilities

Participant Information - *To be completed by the participant, or parent/guardian/caregiver.*

First name: _____ Last name: _____ Middle name: _____

Date of birth (dd/mm/yyyy): _____/_____/_____ Gender: ◯ Female ◯ Male ◯ Other

Email: _____ Phone number: _____ ◯ Mobile ◯ Landline

Home address: _____

Optional – ***Check all that apply:***		
Race / Ethnicity	☐ American Indian / Alaskan Native ☐ Black / African American ☐ Middle Eastern / North African ☐ White / Caucasian ☐ Other: _____	☐ Asian American ☐ Hispanic / Latino ☐ Native Hawaiian / Other Pacific Islander ☐ Unknown ☐ Prefer not to answer
Language(s) Spoken by Athlete	☐ English ☐ French ☐ Spanish ☐ American Sign Language (ASL) ☐ Other (please list): _____	

Parent/Guardian Information - *Required if minor or otherwise has a legal guardian.*

First Name: _____ Last Name: _____ Relationship to athlete: _____

Email: _____ Phone number: _____ ◯ Mobile ◯ Landline

Home address: _____

Emergency Contact ☐ *Same as Parent/Guardian*

First name: _____ Last name: _____ Phone number: _____ ◯ Mobile ◯ Landline

Relationship to participant: ◯ Parent/guardian ◯ Caregiver ◯ Family member ◯ Healthcare provider ◯ Other

Associated Conditions

Associated Conditions ***Check all that apply:***	☐ Autism ☐ Marfan Syndrome ☐ Other	☐ Cerebral Palsy ☐ Spina Bifida ☐ Unknown	☐ Down Syndrome ☐ Epilepsy	☐ Fetal Alcohol Syndrome ☐ Fragile X Syndrome
Please specify other known intellectual disability diagnoses:				

Assistive Devices and Accommodations - *Do you use any of the following? Check all that apply:*

Mobility	☐ Walker ☐ Prosthetics	☐ Braces or crutches ☐ None	☐ Wheelchair	☐ Removable orthotics
Lifestyle Aids	☐ CPAP ☐ None	☐ Dentures	☐ Glasses, contact lenses, or protective eyewear	
Communications	☐ Hearing Aid	☐ Communication devices	☐ Sign Language	☐ None
Medical Devices	☐ Implantable cardioverter defibrillator (ICD) ☐ VP Shunt	☐ Pacemaker	☐ Implantable device for seizure management ☐ None	

Do you have a specific dietary requirement?	◯ Yes	◯ No	If yes, please specify:
Do you use other assistive devices?	◯ Yes	◯ No	If yes, please specify:

General Health Questions

Do you have a heart condition?	◯ Yes	◯ No
Do you have asthma?	◯ Yes	◯ No
Do you have diabetes that requires you to take insulin?	◯ Yes	◯ No
Do you have a vision impairment?	◯ Yes	◯ No
Do you have a hearing impairment?	◯ Yes	◯ No
Do you have a bleeding disorder?	◯ Yes	◯ No
Has a doctor ever limited your participation in sports?	◯ Yes	◯ No
Do you have epilepsy or any type of seizure disorder?	◯ Yes	◯ No
Do you have sickle cell disease?	◯ Yes	◯ No

Have you ever had a concussion?	◯ Yes ◯ No	If yes, please specify how many in your lifetime: _____ Date of last one (mm/yyyy): _____
Do you have behavioral, mental health, and/or sensory conditions?	◯ Yes ◯ No	If yes, please specify:
Do you have severe allergies that requires the use of an EpiPen?	◯ Yes ◯ No	If yes, please specify if it is to any of the following: ☐ Insect stings ☐ Medication/drugs ☐ Food ☐ Latex ☐ Other (please specify): _____

Medication and Treatment - *Please list:*

Are you taking any prescription or over-the-counter medications or treatments? (Including birth control pills, insulin, multivitamins allergy shots or pills, EpiPen, asthma inhalers, epilepsy medication, anti-inflammatory medication, supplements of any kind. etc.)

◯ Yes ◯ No

If yes, please list:

Medication, Vitamin, or Supplement Name	Dosage	Times per day

Medication, Vitamin, or Supplement Name	Dosage	Times per day

Name of person completing the form: _____

Today's date (dd/mm/yyyy): _____/_____/_____

Is this form being completed by someone other than the participant? ◯ Yes ◯ No

If yes, please select the relationship to participant:

Relationship to participant: ◯ Parent/guardian ◯ Caregiver ◯ Family member ◯ Healthcare provider ◯ Other