

Participant Name: _____ Parent's Name: _____

Address: _____ Phone: _____

Date: _____ Email: _____

Program I would like to participate in:

Program Name: _____

Date Beginning: _____ Date Ending: _____ Number of Weeks: _____

Day: _____ Time: _____ am/pm Location: _____

Accommodations used in the past:

- | | |
|--|--|
| <input type="checkbox"/> I use a wheelchair | <input type="checkbox"/> I use assistive mobility devices (<i>braces, crutches, cane, or prosthesis</i>) |
| <input type="checkbox"/> I wear a hearing aid | <input type="checkbox"/> I need to read lips of instructors |
| <input type="checkbox"/> I rely on sign-language interpreting services | <input type="checkbox"/> I have difficulty standing for long periods of time |
| <input type="checkbox"/> I tire easily when I walk distances | <input type="checkbox"/> I have difficulty walking up/down stairs |
| <input type="checkbox"/> Other: _____ | |

Personal assistant information

I will be bringing a personal assistant: yes no

Companion Name: _____ Phone: _____

Email: _____

Additional Information: _____

For Office Use Only

Copies: Companion Program Director File

Supervisor/Coordinator of Activity: _____ Phone: _____

Supervisor Email: _____

Has supervisor been contacted?: yes no

What accommodations will be used? _____
