



# Student Information Form

Please complete the form to the best of your ability. Connect with a BRASS team member if you have any questions or need clarification.

Person Completing Form:  
Email:

Date:  
Phone:

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## GENERAL INFORMATION

Student's Name:

Age:

Gender:

Height:

Weight:

Shoe Size:

Street Address:

City

State:

Zip:

Phone:

E-mail:

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## MEDICAL INFORMATION

Disability:

Onset:

Medications (name, dosage, frequency, & reason for medication):

Past Surgical Procedures (date, any complications):

Secondary Disability:

Please answer the following questions as applicable. If "Yes", please explain below.

- Are you currently under a doctor's care for any condition? Yes No
- Are you allergic to anything? (medications, food, latex, etc.)? Yes No

- Do you have/use an Epi-Pen? Yes No
- Do you have any special dietary requirements? Yes No
- Do you need to limit your activities for any reason? Yes No
- Do you have any special conditions (diabetes, asthma, heart)? Yes No
- Do you have any special medical instructions or information? Yes No

Explanations:

General Physical Condition: Fair Good Excellent

Physical Aids: Walker Wheelchair Crutches Braces

Other (describe below)

## SECONDARY PROBLEMS (Comment as appropriate)

Circulatory in Limbs Diabetes: Yes No If yes, insulin: Yes No

Cardiovascular: Vision Loss:

Seizures: Yes No If yes, controlled with medication? Yes No

Type of Seizure: Date of Last Seizure:

Bladder Management: Self: Yes No Catheter: Yes No Leg Bag: Yes No

Endurance: Normal: Yes No Decreases with Activity: Yes No

Hearing Loss: Yes No Describe:

Sensory Loss: Yes No Pain: Heat & Cold Pressure Circulation in limbs

Other secondary problems:

## MOTOR STATUS

Please list any problems with MUSCLE TONE, RANGE OF MOTION OR STRENGTH in the space below. Also note any spasticity or paralysis and area affected.

## BEHAVIOR & GENERAL ATTITUDES (Enter number to items listed below)

1. Normal - No Problems
2. Mild Problems – Interferes Occasionally;
3. Moderate Problems – Interferes Frequently
4. Severe Problems – Interferes Constantly

Frustration Tolerance	Hostility	Confusion	Anxiety
Memory Loss (Short or Long)	Impulsivity	Following Directions	Temper
Spatial Disorientation	Problem Solving	Distractibility	
Slowness of Cognitive	Slowness of Speech	Ability to Self Correct	

**ACTIVITIES & SPORTS INVOLVEMENT**

New Skier                      Previous Skier:                      Amount of Experience:

Swimming                      Weights                      Soccer                      Sailing                      Basketball                      Ice Skating

Water Skiing                      Walking                      Running                      Gymnastics                      Tennis                      Biking

Other:

**MISC. INFORMATION**

Your Goals for the Ski Season:

School or Place of Employment:

Grade/Class or Position

Usual Number of relative/friends that accompany you to ski area:

How did you hear about our program?

Do you need rental equipment?                      Yes                      No

Do you or a member of your party require assistance or a guide to the BRASS Office?                      Yes                      No