



Participant Information

Please Print Clearly

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Height: _____ Weight: _____ Date of Birth: _____ Male/Female: _____

Occupation: _____ Work Telephone: (____) _____ Fax: (____) _____

Home Telephone: (____) _____ Cellular(____) _____

Email: _____

EMERGENCY CONTACT in COLORADO

Name: _____ Phone: _____

EMERGENCY CONTACT at HOME

Name: _____ Phone: _____

DO YOU NEED RENTAL EQUIPMENT?

SKIERS: Shoe Size: _____ Ski Length: _____ (if known)

BOARDERS: Shoe Size: _____ Goofy (Rt. Ft. Fwd) or Regular (Left Ft. Fwd) R / G

Board Length _____ (if known) Strap or Step-In _____

IMPORTANT: OUR ARRANGEMENT WITH OUR SPONSORS IS THAT WE NEED TO KEEP DOCUMENTATION OF YOUR VISION LOSS ON FILE. PLEASE PROVIDE US WITH A 3RD PARTY VERIFICATION (DR., REHAB COUNSELOR, etc.).

MEDICAL INFORMATION

Please answer the following questions as applicable. If you check "yes" to any question, please explain. Use a separate sheet if necessary.

Do you have medical insurance?

Please describe your vision impairment including level of sight, if any.

What was the cause of loss of vision?

Are you currently under a doctor's care for any condition (other than vision issues)? Yes No Please list

Do you have now, or have you ever had, any hearing loss, problems, or concerns? Yes No Please describe

Are you currently taking any medication(s) about which we should be aware?

Yes No If answer is yes, please list below:

Do you experience seizures? Yes No If yes, do you take anti-seizure medication? Yes No If answer is yes, please list:

Are you allergic to anything? (i.e., medication, food, etc.) Yes No If answer is yes, please list:

Do you have any special dietary requirements? Yes No If answer is yes, please list:

Are you ambulatory? Yes No If answer is yes, % of time _____

Do you need to limit your activities for any reason? Yes No If answer is yes, please list activities below:

Do you have any special medical conditions we should know about? Yes No Please list medical conditions in space provided below: (i.e., asthma, diabetes, heart trouble, etc.)

Do you have any special medical instructions or information we should know about? Yes No Please list special medical instructions in space provided below, or attach a separate page.

In what other physical activities do you participate?

How did you find out about Foresight Ski Guides?

What is your level of skiing (green, blue, black or beginner, intermediate, advanced)

Have you had prior experiences being guided? When? Where?

What are your fears about skiing/snowboarding?

What are your likes/dislikes?

What else we should know?

Thank you for your time. We hope you have a pleasant experience. If you have any questions at all, please contact us.

PLEASE FAX OR EMAIL THIS FORM TO:

Mark G. Davis, President

FAX: 303-894-9383 PHONE: 303-860-0972 (toll free 866-860-0972)

PO Box 18944, Denver CO 80218-0344 Email: Info@foresightskiguide.org