



# Participant Application

Therapeutic Recreation For Youth & Adults  
P.O. Box 2866 \* Great Falls, MT 59403  
406-454-1449 \* eagle\_mountgf@eaglemount.net  
[www.eaglemount.net](http://www.eaglemount.net)

*This section is for office use only:*

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Gender:  M  F Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street Address City State Zip

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Best way to contact you?  Phone  Email  Mail

Please send all correspondence and schedules to:  Self  Other: \_\_\_\_\_

Responsible party for paying Eagle Mount fees \_\_\_\_\_  
(if other than yourself, please attach a Cost/Fee Plan Verification Sheet from party paying your fees)

List programs/activities you are interested in: \_\_\_\_\_

How did you hear about Eagle Mount and what are your expectations?

Parents/Legal Guardian/Caretaker: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### EMERGENCY INFORMATION

Please furnish the name of someone who can be contacted if the above listed are not available, as well as participant's insurance information.

Name	Relationship
Address	Phone
Insurance Company	Group #
Name of Insured Party	Policy #

**MEDICAL INFORMATION: Please fill out thoroughly - your application may be denied if this is not completed in full. WE MUST HAVE THIS INFORMATION TO PROVIDE YOU A SAFE PROGRAM.**

Primary Physician:	Phone:
Specialist Care (name of neurologist, internist, prosthetist)	
Description of Disability (type, level of injury, degree of involvement):	
Ambulatory Status: <input type="checkbox"/> Coordination Problems <input type="checkbox"/> Balance Problems <input type="checkbox"/> Movement Limitations Wheelchair: <input type="checkbox"/> <i>Dependent</i> <input type="checkbox"/> <i>Propels Self</i> <input type="checkbox"/> <i>Electric</i> Ambulatory: <input type="checkbox"/> <i>Independent</i> <input type="checkbox"/> <i>Walker</i> <input type="checkbox"/> <i>Crutches</i> <input type="checkbox"/> <i>Assistance/Supervision</i>	
Medications (dosage, frequency, reactions, reason for use):	
Seizures (if prone to seizures, when, cause, reactions):	
Allergies (medicine, food, other):	
Behavior Modification Techniques to be reinforced:	
Past Surgical Procedures:	
Other Pertinent Information (orthotic/prosthetic apparatus; fears; bladder/bowel management; catheters; sensory loss; skin problems; hearing/visual impairment and apparatus; ciculatory problems; etc.):	
Additional Comments (Your comments/goals for participation in Eagle Mount programs and suggestions are most welcome and very valuable to our success!):	

## Eagle Mount Participant Release of Liability / Information

**Initialing each of the following paragraphs and signing below states that you have read each statement thoroughly, understand that you may have given up substantial rights by initialing and signing this release, have not changed it orally, and initial and sign it voluntarily.**

In consideration of being allowed to participate in any way in Eagle Mount-Great Falls, and/or Disabled Sports USA recreation programs, related events, and activities, I and/or minor participant and on behalf of my heirs, assigns, personal representatives and next of kin, the undersigned:

### **INITIAL**

\_\_\_\_\_ Agree that prior to participating I will inspect to the best of my ability, or if a parent and/or legal guardian I will instruct the minor participant to inspect to the best of his/her ability, the facilities and equipment to be used, and if I believe anything is unsafe, I and/or the minor participant will immediately advise an Eagle Mount-Great Falls staff person of such condition(s) and refuse to participate.

\_\_\_\_\_ Acknowledge and fully understand that I and/or minor participant, will be engaged in activities that involve risk of serious injury, including permanent disability and death, and severe social and economic losses which might result only from my/their own actions, inaction's, or negligence of others, the rules of play, or the condition of the premises or any equipment used. Further, that there may be other risks not known to me or not reasonably foreseeable at this time.

\_\_\_\_\_ Assume all the foregoing risks and accept personal responsibility for the damages following such injury, permanent disability or death.

\_\_\_\_\_ Release, waive, discharge and covenant not to sue Eagle Mount-Great Falls, and/or Disabled Sports USA, its affiliated clubs, their respective administrators, directors, agents, coaches, and other employees of the organization, other participants, sponsoring agencies, sponsors, advertisers, their heirs, and if applicable, owners and lessors of premises used to conduct the event, all of which are hereinafter referred to as "releasees", from demands, losses or damages on account of injury, including death or damage to property, caused or alleged to be caused in whole or in part by the negligence of the releasee or otherwise.

\_\_\_\_\_ Give permission for Eagle Mount-Great Falls to obtain for me emergency medical treatment, as they deem advisable.

\_\_\_\_\_ Give permission for Eagle Mount-Great Falls to use photographs, videos and general information about me in their efforts to publicize their programs.

\_\_\_\_\_ Acknowledge and fully understand that Eagle Mount-Great Falls staff members have the authority to exclude participants from the program for behavior they deem unsafe. Use of alcohol and illegal drugs, or being under the influence, is unsafe behavior.

\_\_\_\_\_ Understand and agree that information regarding Eagle Mount participant or volunteer medical history, family background, and other personal information will be kept strictly confidential.

Y N Have you ever been convicted of any crimes including sexual abuse related offenses? If yes, explain on back.

\_\_\_\_\_ Eagle Mount reserves the right to verify this information which may include a criminal background check.

Applicants who provide false information will be disqualified or terminated from participating or volunteering with Eagle Mount.

I have read the above statements & understand that I may have given up substantial rights by signing and sign voluntarily.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

### **Request for Information:**

I, \_\_\_\_\_, give consent to any physician, hospital, school or clinic to release whatever information is requested concerning the diagnosis and/or treatment of \_\_\_\_\_, date of birth \_\_\_\_\_, to Eagle Mount - Great Falls. This information will be utilized by the Eagle Mount professionals to determine the most appropriate participation for the above named individual and will be treated as confidential.

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date