Eagle Mount Great Falls
P.O. Box 2866
Great Falls, MT 59403
Phone: (406) 454-1449, Fax: 454-1780
eaglemountgf@gmail.com

Area for Office Use Only:
☐ Online Waiver _____/_____/_____
☐ Paper Waiver _____/_____/_____
☐ Medical Rel. _____/_____/_____
Media ☐ Yes ☐ No

PARTICIPATION APPLICATION

PARTICIPANT INFORMATION			
First Name:	**Middle Initial:**	**Last Name:**	**Date of Birth:**
Address:	**Sex:** ☐ M ☐ F	**Height (ft,in):**	**Weight (lbs):**
City:		**State:**	**Zip:**
Home Phone:	**Mobile:**	**Work:**	
Email Address:			
Check best way(s) to reach you: ☐ Mail ☐ Email ☐ Home ☐ Mobile ☐ Work ☐ Text			

SERVICE (check all that apply)			
☐ **VETERAN**	☐ **MILITARY ACTIVE DUTY**	☐ **1st RESPONDER (EMS, Fire, Police)**	☐ Active ☐ Retired

PARENT/LEGAL GUARDIAN INFORMATION (IF PARTICIPANT IS A MINOR OR LEGALLY INCAPACITATED)		
First Name:	**Last Name:**	**Relationship:**
Address (if different than above):		
City:	**State:**	**Zip:**
Home Phone:	**Mobile:**	**Work:**
Email Address:		

EMERGENCY CONTACT		
First Name:	**Last Name:**	
Relationship to Participant:		
Home Phone:	**Mobile:**	**Work:**

MEDICAL INFORMATION	
Disability/Diagnosis (please do not use acronyms):	
Primary Care Physician:	**Specialist Care** (i.e. Neurologist, Physical or Occupational Therapist, Counselor):
Date of injury or onset of disability (optional):	**Assistive Device(s) or Prosthetics Used** (include any spinal stabilization):
Are you able to walk? ☐ Y ☐ N *If YES, please indicate for how long/far?*	
Do you use a wheelchair? ☐ Y ☐ N *If YES,* ☐ *Confined* ☐ *Transfers independently* ☐ *Transfers with assistance*	

Find Us!
www.eaglemount.net or **eaglemountgf** on

Currently taking any medications that could affect your participation with us? ☐ Y ☐ N *If YES, please list all, including over-the-counter*

Do you have allergies? ☐ Y ☐ N *If YES, please list:*

Do you carry an EpiPen? ☐ Y ☐ N **Do you carry an Inhaler?** ☐ Y ☐ N

PLEASE INDICATE YES OR NO TO EACH QUESTION. IF YES, PLEASE DESCRIBE TYPE AND SEVERITY

Traumatic Brain Injury?	☐ Y ☐ N	
Post-Traumatic Stress and/or Anxiety?	☐ Y ☐ N	
History of seizures or seizure disorder? *If yes, please describe what kind, last known seizure, how often, any known triggers and how long it lasts.*	☐ Y ☐ N	
Blind or visually impaired?	☐ Y ☐ N	
Deaf or hard of hearing?	☐ Y ☐ N	
Limited range of motion in any limbs?	☐ Y ☐ N	
Difficulty with balance or coordination?	☐ Y ☐ N	
Any type of paralysis?	☐ Y ☐ N	
Sensitivity to hot or cold?	☐ Y ☐ N	
Difficulty speaking or communicating?	☐ Y ☐ N	
Memory loss and/or difficulty remembering or following directions?	☐ Y ☐ N	
Emotional and/or behavioral concerns?	☐ Y ☐ N	
If Down Syndrome – any history of Atlantoaxial Instability? *(Please state date of last x-ray)*	☐ Y ☐ N	
Cognitive or developmental delay?	☐ Y ☐ N	
Heart/Cardiac condition?	☐ Y ☐ N	
Breathing difficulties and/or respiratory condition?	☐ Y ☐ N	

Please list doctor restrictions (including driving) or any other medical conditions, concerns, or behavioral/emotional triggers not mentioned above:

PARTICIPATION INFORMATION
What are your activity interests and your expectations from participating in our programs/activities? www.eaglemount.net *You will receive detailed program information based on your application answers. Some programs will have supplemental questionnaires to assist in providing safe and fun activities. You will be contacted within two weeks of receiving your application.*
What brought you to Eagle Mount Great Falls?
What do you currently do for exercise and how often?
Will a caregiver be accompanying you? ☐ Y ☐ N *If YES, please list name and contact information:*
Have you ever been convicted of any crimes including sexual abuse related offenses? ☐ Y ☐ N *If YES, explain:*
Please provide any additional information or concerns that you feel will help us create a successful experience for you:

ACKNOWLEDGEMENT
I certify that the information provided on this form is true and correct to the best of my knowledge. Eagle Mount Great Falls reserves the right to verify all information. Anyone who provides false information will be disqualified from participating or volunteering. ✓ **I understand that some Eagle Mount Great Falls activities/programs may not be suitable or appropriate for me or my child. I, or my child, will be evaluated for proper placement into Eagle Mount Great Falls programming.** ✓ **I understand that anyone participating in any Eagle Mount activity must have a liability form signed before attending. Media waivers are optional but we hope you sign it so we can share your adventures on our media sites and website. Waivers can be signed online at https://www.waiverfile.com/b/EagleMountGreatFalls/ or you can download a paper copy from www.eaglemount.net or request a paper copy.**

Printed Name:	**Date:**
Signature:	
If the participant is under 18 or legally incapacitated, this section must also be completed:	
Parent/ Legal Guardian Printed Name:	**Date:**
Parent/Legal Guardian Signature:	**Relationship:**

Participant's Consent for Release of Information

I hereby authorize any physician, hospital, clinic, school, psychologist, psychiatrist, and/or counselor to release

information from the records of _____ D.O.B. _____.
(participant's name) (date of birth)

The information is to be released to **EAGLE MOUNT GREAT FALLS** for adaptive recreational activities. For more information on our programs, please see our website, www.eaglemount.net, or give us a call at 454-1449.

For determining the most appropriate and safe activities in any of the above programs, Eagle Mount Great Falls may request one or more of the following information. All information will be treated as confidential and only used for programming purposes.

- Medical evaluation/history
- Physical, Occupational and/or Speech therapy evaluation, assessment and program plan
- Classroom Individual Education Plan (IEP)
- Psychosocial evaluation, assessment and program plan
- Cognitive-Behavioral management plan

This release is valid for one year and can be revoked, in writing, at my request.

Signature: _____ Date: _____

Printed Name: _____

Relation to Participant (if other than self): _____

Notice of Information Practices and Privacy Statement for Eagle Mount Great Falls (EMGF)

Eagle Mount Great Falls, P.O. Box 2866, Great Falls, MT 59403. www.eaglemount.net (406) 454-1449

How We Collect Information About You: Eagle Mount Great Falls (EMGF) and its employees and volunteers collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voicemails, and from the submission of applications that are either required by law or necessary to process applications or other requests for assistance through our organization.

What We Do Not Do With Your Information: Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voicemails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about participants or volunteers who apply for or receive our services that are considered confidential, is restricted by law, or has been specifically restricted in a signed HIPAA consent form.

How We Do Use Your Information: Information is only used as is reasonably necessary to process your application or to provide you with safe recreational adaptive activities which may require communication between EMGF and health care providers, medical product or service providers, and other providers necessary to: verify your information is accurate and determine the most appropriate and safe activities in any of the EMGF programs.

If you apply or attempt to apply to receive services through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Information We Do Not Collect: We do not use cookies on our website to collect data from our site visitors.

Limited Right to Use Non-Identifying Personal Information from Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of EMGF. We reserve the right to use non-identifying information about our participants and volunteers for fundraising and promotional purposes that are directly related to our mission.

No one will be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without express advance permission.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

I have read and understand EMGF's Privacy Statement.

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