City of Chariton, Can Play Adapted Sports Registration Form

Participant Name: _____Gender Identity:

Date of Birth:_____Grade:_____T-shirt Size:_____

Address: _____

Participant's Information

Please provide us with some information about your participant to ensure their safety in our programs.

Primary Diagnosis: _____

Other Medical or Diagnosis:_____

Allergies:_____Seizures? _____Yes _____No

Mobility: Independent _____ Yes _____ No _____ Some support needed

If not, list the participant's primary means of mobility (i.e. power wheelchair, walker, etc.)?

_____

Describe the level of assistance needed: _____

Method of Communication *(i.e. verbal, sign language, speech device):* _____

Additional information that would be helpful for us to know: _____

Favorite activities or hobbies: _____

Parent/Guardian/Caregiver Information

Name: _____ Relation to Participant: _____

Phone: _____ Secondary Phone: _____

Email: _____

Emergency Contact Info

Name: _____ Relation to Participant: _____

Phone: _____ Secondary Phone: _____

Email: _____

Programs and Dates Registering for: _____