BURKE REHABILITATION: ADAPTIVE SPORTS & RECREATION

Before you participate in Burke's Adaptive Sports & Recreation program, this form must be completed in its entirety. This information is essential to our ability to facilitate a successful experience. All sections must be completed thoroughly and accurately. A physician must sign the medical form.

Today's Date (MM/DD/YYYY): ____ /____ /_____

Name(s) & Date(s) of clinics/program(s) you are registering for: _____

_____

Contact/Biographical Information

Name:_____ Home Phone:_____

Email: _____ Cell Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Name of Parent/Guardian (if applicable): _____

Relation to participant: _____ Parent/Guardian Phone: _____

Emergency Contact: _____ Relation:_____ Phone: _____

Primary Physician: _____ Physician Phone: _____
(If no primary physician, please list 2nd emergency contact) (or 2nd emergency contact number)

Disability/Medical Information

Date of Birth (MM/DD/YYYY): ____ /____ /_____ Height:_____ Weight:_____ Gender:_____

Participant Disability/Diagnosis: ***BE SPECIFIC! LIST ALL THINGS THAT MAY AFFECT YOUR PARTICIPATION!****

For Example Cardiac; Diabetes; Pulmonary; Orthopedic; etc.)

_____

_____

_____

Are there any mental health/behavioral needs of which staff should be made aware?

_____

_____

If disability was caused by injury/incident, please give the date (MM/DD/YYYY): ____ /____ /_____

Any injuries/surgeries in the past year? _____

_____

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Current Medications? Please list: _____

_____

Allergies (food, medications, latex, bees, other): _____

Do you have a known anaphylaxis reaction to the allergen above? _____

If yes- do you carry and Epinephrine Auto Injector (EpiPen)? _____

If yes-do you give Burke permission to administer your epinephrine to you if you are unable to do so?_____

Have you ever had a seizure(s)? _____ Date of last seizure (MM/DD/YYYY): ____ /____ /_____

Seizure management (Meds, etc.) _____

Can participant wear a helmet? _____

Please describe any other medical concerns that may affect participation: _____

_____

_____

Physical/Social Information

Mobility: ___Independent ___Requires extra time ___Needs assistance

Devices used to aid mobility (check all that apply):

___Braces ___Walker ___Cane ___Manual wheelchair ___Power wheelchair ___Crutches ___Other:

_____

Transfers: ___Independent ___Supervision ___Minimal Assistance ___Moderate Assistance ___Maximal Assistance

If you need help with transfers, do you have an aide? _____

Please describe all pertinent information regarding transfers: _____

_____

Please describe any hearing and/or visual issues and any special needs/concerns: _____

_____

Please describe any pertinent information regarding the participant's means of communication and interactions with others. Please include any stressors, motivators, or other relevant information.

_____

Continued >

Please describe your…	**Left Side**	**Right Side**
Arm strength		
Hand grip strength		
Arm/Hand sensation (numbness, tingling, etc.)		
Arm range of motion		
Leg strength		
Leg/Foot sensation (numbness, tingling, etc.)		
Leg range of motion		

How did you hear about us?

_____

_____

What activities are you (the participant) interested in participating in?

___Water Skiing	___Fishing	___Archery	___Field Events	___Pickleball
___Hand Cycling	___Snow Skiing	___Sailing	___Expressive Arts	___Dance
___Rock Climbing	___Kayaking	___Tennis	___Softball	___Power Soccer
___Boxing	___Golf	___Table Tennis	___Theater/Improv	___Other

Please describe your experience w/your selected activities, including equipment adaptations, personal goals, and any other specific information that will help us prepare for your participation:

_____

_____

Would you like to know more about our other programs, and stay up to date to our upcoming programs and available resources? (I.E. Fitness classes, fitness challenge, cycling races, fundraisers, wheelchair games, etc.)

___Yes! Email: _____

___No thank you

BURKE ADAPTIVE RECREATION RELEASE

RELEASE OF LIABILITY (required)

I/we hereby for ourselves, our heirs, administrators and assigns, waive and release any and all claims against The Burke Rehabilitation Hospital and its employees, contractors and volunteers, for any and all injuries and/or expenses incurred by me/us while using any related recreation equipment (such as McClain Training Rollers, Quad Grips, helmets, Hand Cycles, Golf Clubs, Climbing Equipment, Kayaking Equipment, Table Tennis Equipment, etc.) during participation in clinics, classes, workshops, practices, training, rides or competition.

Printed Name of Participant: _____

Signature of Participant: _____ Date: _____

Legal Guardian: _____ Date: _____

Questions? Call (914) 597-2248 and leave a message.
We will return your call as soon as possible.

After you have completed this form in its entirety, please return to:

Recreational Therapy c/o Eileen Andreassi
Burke Rehabilitation Hospital 785 Mamaroneck Ave.
White Plains, NY 10605
AdaptiveSports@Burke.org
FAX: 914-597-2829

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OFFICE USE ONLY

Project: _____ Location: _____ Date: ____ / ____ / ____

☐ M ☐ F Age: _____ Note: _____ *Rev 5/2020*

BURKE
Rehabilitation Hospital
MEMBER OF MONTEFIORE HEALTH SYSTEM

CONSENT AND RELEASE FOR USE OF IMAGES

I, _____, hereby agree to grant to Burke Rehabilitation Hospital its parents, successors, affiliates (hereinafter "Burke") and all persons acting under its permission or authority including, but not limited to, its parent, successors, affiliates (hereinafter "Burke") employees and other persons it may engage ("Licensees"), to interview me, have permission to photograph, publish, reproduce, record and use photographs, motion pictures, videotapes or audio tapes (collectively referred to as "Images") of me , in order to memorialize the medical care, surgery, any other procedures to be performed, my presence at Burke facilities, attendance at Burke events and/or participation in Burke research studies. The Images may be used for any and all purposes, including but not limited to distribution to the media, educational, promotional, publicity, advertising and fundraising purposes, as well as for possible publication by Burke in various traditional and social media (e.g. Facebook) and on the Internet. I acknowledge and agree that neither Burke will pay me, my children, or my legal ward while a patient at Burke in any manner for such photographing/ recording and use of the Images. I grant this permission and release as a voluntary contribution and I waive any and all rights I (or my child) may have to royalties or other compensation in connection with any such publication or use. I hereby waive my right to inspect and/or approve the finished products and final usages. I hereby release and discharge Burke from any liability by virtue of any blurring, distortion, alteration, optical illusion or use in composite form that may occur or be produced in the creation

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I hereby release Burke, its trustees, officers, employees, physicians, agents and assigns from any and all legal liability that may arise from any of the foregoing and I waive any and all rights I (or my child) may have to royalties or other compensation in connection with any of the foregoing.

Name (PRINT): _____ Signature: _____

Address: _____ Date: ____ / ____ / ____

Email address (optional): _____ Phone: _____

Witness:

Name (PRINT): _____ Signature: _____ Date: ____ / ____ / ____

MEDICAL CLEARANCE FORM

Your patient _____ has applied to participate in an Adaptive Sports & Recreation program at Burke Rehabilitation Hospital which requires your medical clearance prior to participation. Clearance indicates that this patient has no contraindications for participation in active sports or passive recreation activities.

My patient, _____ is physically able to participate in the Adaptive Sports & Recreation program.

Please list any restrictions or concerns (including medications).

_____

_____

COVID 19 Attestation: My Patient ____**had** ___**has not had COVID**. **If Yes: when?** _____
Received ___**Moderna** Vaccine: ____1 dose ____Both Doses
___**Pfizer** Vaccine: ____1 dose ____Both Doses
___**Johnson & Johnson** Vaccine: _____1 dose

Doctors Details

Name: _____ Phone No: _____

Email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Signature: _____ Date: _____

Please fax, email or return paper form to:

Eileen Andreassi, MA, CTRS
Director of Recreational Therapy & Adaptive Sports
Burke Rehabilitation Hospital
adaptivesports@burke.org
914-597-2248 914-597-2829 (fax)