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BlazeSports Veteran Registration and Medical Form

First Name ______________________________ Last Name ____

Age ______________ Birth date (dd/mm/yyyy) ____________________ Male Female

Address______________________________City__________________State____________ Zip __________

Primary Phone________________________________Alternate Phone __________________________________

Email Address____

Emergency Contact Name __________________________ Emergency Phone____________________________

Physical Disability/Mobility Challenges____

Secondary Disability (brief description)(if applicable) __________________________

T-Shirt Size____________________________

Which military branch did you serve with? ____

When did you separate from military service? ____

What area(s) of BlazeSports are you interested in? **(Circle all that apply)**

Archery Boccia Bowling

Cycling/Handcycle Golf

Kayaking Table Tennis Swimming

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Medical Information

Doctor's Name ____________________________ Doctor's Number __________________

Primary Medical Insurance Company ____

Policy Holder (name) __________________________ Policy Number ________________

Date of Last Tetanus Shot ___________ Date of Last Physical Exam______________

Have you been diagnosed with PTSD? Yes No

If yes, please explain severity:

____

____

Are all of your immunizations up to date? Yes No

If not, please specify which immunizations are currently not up to date:

____

____

Do you have any allergies (i.e. latex, food, medication) Yes No

If so, please be specific in describing the symptoms of an allergic reaction:

____

____

Current Medications (include name and dosage):

____

____

____

Please list any previous surgeries and dates on which they were preformed:

____Date_______________

____Date_______________

____Date_______________

History of Seizures: Yes No If yes, give date of most recent_______________

Do you have a shunt? Yes No Date of original shunt_________________

Have you had any shunt revisions? Yes No Date of revision ________________

Do you have diabetes? Yes No If yes, date of diagnosis ____________________

How is it controlled? (Circle all that apply)

Diet/Exercise Oral Medication Sub-Coetaneous Insulin Insulin Pump Not Controlled

Do you have a history of heart disease, heart problems or high blood pressure?

Yes No If yes, please explain:

____

____

Have you ever had a brain injury or concussion? Yes No

If yes, please give the approximate date and describe the incident:

____

____

____

Do you have any problems with (circle all that apply):

Overheating Autonomic Dysreflexia Pain

If any apply, please describe:

____

____

Do you have scoliosis? Yes No Have you had a back fusion? Yes No

If yes, what level? _______

Do you currently have any pressure sores? Yes No

If yes, where are they and how are you treating them?

____

____

Are you continent of bladder? Yes No

Are you continent of bowel? Yes No

What type of bladder management do you use?

None Indwelling Catheter Intermittent Catheter

If intermittent, what is your cathing schedule? ______________________________

Participant Name (Printed)____

Participant Signature_____________________________________Date:___________