**PARTICIPANT FORM**

Participant Name: ­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Last First Middle*

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

*Street City State Zip*

County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Name (*If applicable)*: \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant would like to: □ Ski □ Snowboard □ Snowshoe □ Snow tube

***Due to manufacture requirements there is a 250 lb. limit on sit skis***

Rentals Required: Yes No Shoe Size (if renting): \_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: Female Male DOB: \_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_

Ethnicity (Ex: Caucasian, Native American, Asian, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you previously participated in Annie’s House Adaptive Recreation Program? □Yes □No

Please check the **primary disability**:

□ Cerebral Palsy □ Amputee □ Downs Syndrome

□ Hearing Impairment □ Developmentally Delayed □Muscular Dystrophy

□ Multiple Sclerosis □ Post Traumatic Stress □Spina Bifida

□ Spinal Cord Injury □ Stroke □Traumatic Brain Injury

□ Visual Impairment □ Autism Spectrum

□ OTHER (please describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Specifics of primary disability**: ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Secondary Disability/ies**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have Atlantoaxial instability?\* □ Yes □ No

\*BWP encourages participants with Downs Syndrome to be evaluated for Atlantoaxial instability

**Medications □ Not applicable** \*Annie’s House does not administer medications

|  |  |  |
| --- | --- | --- |
| Medication | Dosage and schedule | Reason for taking |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Please describe any side effects that we should be aware of:**

**Activities of daily living** (*mobility, hygiene, meals, etc.*)

\*Annie’s House does not administer medications or assist with toileting participants

□ **Independent** (freely ambulates or independently uses wheelchair, crutches, walker, can; transfers to and from vehicles and navigates on own, managers on medications, meals, bathroom needs including catheterizations)

□ **Assisted** (requires assistance with transfers to and from vehicles or toileting; continues to manage own meals, medications, and crowds)

□ **Dependent** (requires someone else to perform all the activities of daily living with them)

**SEIZURES: History of seizures: □ Yes □ No**

Type of seizures: □ Petit Mal □ Grand Mal □ Focal

Date of last seizure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Controlled by Medication? □ Yes □ No

**Sports experience:** Please circle all the activities that the applicant has previously participated in

Skiing (beginner, novice, intermediate) Snowboarding (beginner, novice, intermediate)

Swimming Biking Soccer Baseball/Softball Basketball Hockey

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Level of stamina:** □ Fatigues easily □ Age appropriate strength/energy □ Varies

**If you have participated in another adaptive program please provide the name of the program and equipment you used: □ Not applicable \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list medical procedures and implanted devices - include locations and approximate date of procedure** (*i.e. fracture repairs with rods & pins, shunts, feeding tubes, insulin pumps, catheter*)

□ Not applicable

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Food or Drug Allergies □ No known allergies □ Latex allergy □ I have an epi-pen**

\*if necessary please use a separate page

|  |  |
| --- | --- |
| Allergy | Reaction |
|  |  |
|  |  |
|  |  |

**Mobility – Body Movement**

**Mobility needs** (*i.e. power/manual wheelchair, crutches, cane, AFO*): ­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check any that apply:**

**□** Hemiplegia □ Poor Coordination □ Poor Hand-Eye Coordination

□ Spasticity □ Poor Muscle Tone □ Muscle Spasms

□ Joint Rigidity □ Contractures □ Altered Gait

□ Poor Balance □ Involuntary Movements □Hyperflexibility

**Spinal Cord Injury:** Location (*i.e. T-4, C-6)* \_\_\_\_\_\_\_\_\_\_\_\_

□ Complete □ Incomplete □ Paraplegia □ Quadriplegia □ Autonomic Dysreflexia

**Amputee:** Please describe type of amputation

□ Right □ Left □ Bilateral

□ Above knee □ Below knee □ Complete upper limb

□ Above elbow □ Below Elbow □ Complete lower limb

Do you intend to wear your prosthesis while taking part in the program? □ Yes □ No

**Communication**

**Please check any that apply:**

□ Non-verbal □ Speaks in single words □ Speaks in 2-3 word phrases

□ uses personal sounds □ Uses gestures/points □ Speaks in complete sentences

□ Uses pictures/cue cards □ Uses communication board □ Writes/draws wants and needs

□ Expressive language delays

Anything else we should know? ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Cognitive**

□ Sequencing difficulty □ Processing delay □ Learning disability

Please let us know any other specifics: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Behavior**

**Behavior and general attitude:**

*Enter the numbers to the items below: 1 = normal, 2= mild problem, 3= moderate problem, 4= severe problem*

**\_\_**Frustration tolerance \_\_Confusion \_\_Anxiety \_\_Temper

\_\_Impulsiveness \_\_Following directions \_\_Memory loss

\_\_Spatial disorientation \_\_Hostility

What is the participant’s functional age? \_\_\_\_\_\_\_\_\_\_\_\_\_

*Please check any that apply*

□ Hyperactivity □ Elopement □ Extreme emotional responses

□ Uncooperative □ Does not consider consequences □ Angers easily

□ Social delays □ Easily distracted by sensory stimuli □ Unaware of limitations

□ Ignores details □ Difficulty staying seated or in line □ Low activity level – needs motivation

□ Appears forgetful □ Excessive talking/interrupts frequently □ Difficulty with abstract thoughts

□ Short attention span □ Difficulty following directions/finishing tasks

Please describe behaviors the instructors should be aware of – triggers, methods to soothe, best way to reward participant (verbal, high-five, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hearing**

Hearing impairment: □ Partial hearing loss □ Total hearing loss

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the participant: □ Wearing hearing aid(s) □ Has a cochlear implant □ Communicate with ASL

Anything else we should know? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vision**

Visual impairment □ Partially sighted/legally blind □ Complete blindness

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cause for the visual impairment:

□ Cataracts □ Macular Degeneration □ Diabetes

□ Retinopathy □ Retinitis Pigmentosa □ Optic Atrophy

□ Glaucoma □ Trauma

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To aid in mobility does the participant use: □ cane □ guide □ guide dog

Anything else we should be aware of? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**May Annie’s House use the participant’s image (video and/or photography)?** □ Yes □ No

Information above is confidential and will only be shared with ski instructors/ski patrol involved in participant’s lesson, to prepare for the lesson.

**Parent/Guardian signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ANNIE’S HOUSE/ANNE CARLSEN

RELEASE AND WAIVER OF LIABILITY, ASSUMPTION OF RISK AND INDEMNITY AGREEMENT

Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In consideration for and as a condition of my above-named child’s/ward’s participation in activities, events, programs, and travel (“activities”) sponsored by Annie’s House and Anne Carlsen Center (“Anne Carlsen”) for which I am registering and, on behalf of myself and my child, I agree as follows:

**Assumption of the Risk**

**I understand that participation in activities administered by Annie’s House and Anne Carlsen may be potentially dangerous and that my child/ward may be injured as a result of participating in these activities. As such, I, on behalf of my child/ward, do hereby assume all risks associate with these activities including** death, injury or illness from accidents of any nature whatsoever and theft or loss of personal property during the camp.

Release, Waiver of Liability, and Indemnification

I, on behalf of my child/ward, myself, and our heirs, personal representatives, successors, assigns, insurers, and other third parties, hereby release, waive, forever discharge, covenant not to sue and agree to indemnify, hold harmless, and defend Annie’s House and Anne Carlsen, its governing board, officers, agents, employees, and volunteers from and against any claims, losses, damages, and expenses, including but not limited to, medical bills, court costs, attorneys fees, and property damage or injuries, including death, to my child/ward because of their participation in any Annie’s House and Anne Carlsen sponsored activities, events, or programs, whether caused by the negligence of Annie’s House and Anne Carlsen to the maximum extent permitted by law.

I acknowledge that, by signing this document, I am giving up substantial legal rights and understand that this intake and release form is a contract with legal and binding consequences and that it applies to all activities sponsored by Annie’s House and Anne Carlsen in which my child/ward engages in, regardless of whether such activity is a part of a formal program.

Release for Personal Property

I acknowledge and agree that Annie’s House and Anne Carlsen, and its agents, employees, representatives, volunteers and assigns shall not be liable for any loss or theft of personal property and I release Annie’s House and Anne Carlsen, and the aforementioned from any liability for loss or theft of any personal property.

Consent for Medical Treatment

I hereby give my consent to have my child/ward treated by emergency medical personnel, a physician, or surgeon, in case of sudden illness or injury while participating in activities sponsored by Annie’s House and Anne Carlsen. I understand that no insurance coverage for participants in these activities is provided by Annie’s House and Anne Carlsen and that the cost of medical care will be at my expense.

I agree to indemnify and hold harmless Annie’s House and Anne Carlsen for any costs incurred to treat my child/ward and I further agree to release, waive, discharge, covenant not to sue, and agree to hold harmless for any and all purposes, Anne Carlsen from any and all liabilities, claims, demands, injuries (including death), or damages, including court costs and attorney’s fees and expenses, that may be sustained by my child/ward while receiving medical care or in deciding to seek medical care, including while traveling to and from a medical care facility, including injuries sustained as a result of the sole, joint, or concurrent negligence, negligence per se, statutory fault, or strict liability of Annie’s House and Anne Carlsen.

Consent to Disclose Protected Health Information

I understand that disclosure of my child’s/Ward’s protected health Information, as defended by the Health Insurance Portability and accountability Act (HIPAA), to third parties may be required in order for my child/ward to successfully participate in registered activities and I agree to permit Annie’s House and Anne Carlsen to disclose my child’s/ward’s PHI and medical information on the intake forms to instructors, ski patrol, and other Winter Park staff to make sure they are knowledgeable about medications, side effects, disabilities, etc.

I understand that I have the right to revoke this consent to disclose protected health information of my child/ward at any time.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS ENTIRE DOCUMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT IT AFFECTS YOUR LEGAL RIGHTS, AND AGREE TO BE BOUND BY ITS TERMS.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_