Abilities Movement PT
Registration Form:

Name: _____ Birthday:_____

Address:(Full mailing address)_____

Contacts- Home #:_____ Cell#:_____

Email: _____

Emergency Contact:_____ Number:_____

Program Registration: Please indicate what programs you would be registering for or interested in.

1. Programs Interested in:_____

Participant Survey: Please complete this form once a year. It will be used for developing the best program plan around each participant. Please complete all areas to the best of your abilities.

1. Documented Disability:_____
2. Areas of Interest/Dislikes:_____

_____

Communication: ❑ Verbal ❑Non Verbal, communication used:_____

3. Level of Mobility: Please check one ❑Ambulatory ❑Ambulatory / Assistive Devices

❑ Manual/Power Wheelchair(Self-Propelled) ❑ Wheelchair (Assistance Needed)

4. Level of Support Needed: please check one:

❑Independent ❑ Independent / Some Assistance ❑ 1 on 1 Support Needed

If 1 on 1 support needed, please describe level of support:_____

_____

____

5. Allergies/Dietary Restrictions:_____

Personal and Confidential
Please return to:
Abilities Movement
144 Fairport Village Landing, # 332
Fairport, NY 14450
(585) 690-4408

6. Other Special Considerations: _____

LIABILITY/WAIVER STATEMENT (All participants and legal guardians MUST complete and sign below):

I, _____, do hereby agree to hold harmless Abilities Movement and its officers, directors, employees, volunteers and others assisting in the programs administered by Abilities Movement. I fully agree that material aspects of the program have been explained to me and that I fully understand the risks and liabilities of the recreation programs and solely assume such risks. If parental or guardian confirmation is required by Abilities Movement to participate in any of our programs, I hereby agree to have such person or persons sign such release on my behalf.

I acknowledge that I am signing this waiver to be in effect for one year from the date of the signature. This waiver will cover all recreational programs accessed through AM.

I acknowledge that I am either covered directly or indirectly for hospitalization insurance in the state of New York and this coverage is primary for any injury sustained in this program.

I, _____, give permission to AM instructors to authorize

medical care for _____ in the event of an emergency.

I agree that the above information is accurate to the best of my knowledge. I agree to contact Abilities Movement, Inc. in the even any of this information changes.

_____ _____

Print Name Signature

_____ _____

Date Guardian Signature (If under 18)

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