moveABILITY

**Kayak Class Registration / Health History Information Sheet** (CONFIDENTIAL)

The following information is requested to maximize fun, learning and safe participation on and off the water and to respond to emergency situations. We strive to accommodate a wide range of abilities. *Information is Confidential.** Please contact us if you have questions.

Name: _____ Preferred Pronoun(s): _____
Address: _____
City / State / Zip: _____ Email: _____
Phone # : _____ Alternate Phone: _____
Height: _____ Weight: _____ Date of Birth: _____ Age: _____

*Emergency Contact Information:* Relationship: _____
Name: _____ Email: _____
Address: _____
City / State / Zip: _____
Phone # : _____ Alternate Phone: _____

Course Registering For / Dates (if private instruction, please share objectives):

Swimming ability (with or without life jacket):

Paddling / kayaking experience:

**This course follows ACA (American Canoe Association) Course Guidelines**

ACA courses are open to all individuals who acknowledge the ability to perform Essential Eligibility Criteria (EEC) and course pre-requisites, included in course outline.

**Essential Eligibility Criteria / Course Prerequisites**:

- ☐ I have reviewed EEC and course prerequisites and meet both
- ☐ I have reviewed EEC and course prerequisites and have further questions
- ☐ I have not received EEC and course prerequisites

**For additional information contact**: Nancy Uschold (she) nancy.moveability@gmail.com 906 458 2450

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**Mark the best answer:**

| | | | |
|---|---|---|---|
| Can you seal your airway passages while under water? | ☐ Yes | ☐ No | ☐ I don't know |
| Do you use any type of external head /neck support? | ☐ Yes | ☐ No | ☐ I don't know |
| Are you able to wear a properly fit life jacket (PFD)? | ☐ Yes | ☐ No | ☐ I don't know |

**Health History**: Your assistance is requested to optimize group and personal safety / success throughout the course. The following questions are optional and will remain confidential.

**Pertinent Health Information**: ***please check YES if an area of concern***

| *Condition* | *Yes* | *No* | *Condition* | *Yes* | *No* | *Condition* | *Yes* | *No* |
|---|---|---|---|---|---|---|---|---|
| Fitness | ☐ | ☐ | Mobility | ☐ | ☐ | Heat sensitivity | ☐ | ☐ |
| Endurance | ☐ | ☐ | Balance | ☐ | ☐ | Cold sensitivity | ☐ | ☐ |
| Injury(s) | ☐ | ☐ | Communication | ☐ | ☐ | Seizures | ☐ | ☐ |
| Asthma | ☐ | ☐ | Hearing | ☐ | ☐ | Other: | | |
| Allergy(s) | ☐ | ☐ | Vision | ☐ | ☐ | Other: | | |
| Heart Condition | ☐ | ☐ | Sensory Loss | ☐ | ☐ | Other: | | |

**Additional Information (use additional page(s) if needed):**

**Current medications / side effects:**

**Request for accommodation(s):**

I attest the information on this form is correct, to the best of my knowledge.
Name (print): _____ Signature & date: _____

If registrant is a minor provide guardian information below:
Name (print): _____ Signature & date: _____

***Please note:** This information is confidential. Email is not secure.
Please MAIL this form to:
*Bay Cliff Health Camp PO Box 310 Big Bay, MI 49808*

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