



Gliding Stars of Findlay Skater Registration for the 2009-2010 Season

Please print and complete all items. Ethnic information is for statistical reporting purposes only. Diagnostic information is for Gliding Stars use only.

Skater Information

Name: _____
(First) (Middle) (Last)

___ Male ___ Female Date of Birth: _____

Street: _____

City/State: _____ Zip: _____

Phone: _____

E-mail: _____

Skater Height _____ Weight _____

Ethnicity: ___ White/Caucasian ___ Black/African American
___ Native American/American Indian
___ Hispanic ___ Asian/Pacific Islander

Skater's School: _____

Is skater eligible for free or reduced fee school lunch program at school? ___ Yes ___ No

How many years has the skater participated in our program? _____ years

Chapter Information

Gliding Stars of Findlay

P.O. Box 1561

Findlay, OH 45839

TEL: 419-423-4536

Email: fndoha@glidingstars.org

Please provide the names of any clubs, service groups, special interest groups, churches, corporations, etc. that you are affiliated with. This Gliding Stars Chapter has formed a Speaker's Bureau, and will provide a speaker at meetings or events as invited.

Notes For Chapter Use Only:

Parent/Guardian Information

Parent/Guardian Name:

Address (if different from Skater's address above):

Phone: _____

E-mail: _____

Alternative Emergency Contact:

Name: _____

Phone: _____

Gliding Stars of Findlay

Skater Registration for the 2009-2010 Season *(Continued)*



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Diagnostic Information *Please check all that apply to skater.*

Skater wears braces/AFOs
 Yes No

Skater can walk/ambulatory *(please clarify:)*
 How far daily? _____
 Assistance Needed: _____

Skater uses an assistive device?
 Wheelchair
 Crutches
 Other

Skater has use of hands?
 Yes No

Skater has a Hearing Impairment ?
 Yes No

Hearing Aid?
 Yes No

How does skater communicate?
 Sign Language
 Reads Lips
 Non-verbal
 Verball

Does Skater have functional vision?
 Yes No

Skater has seizures *(please clarify:)*
 What type? _____
 How Often? _____
 Typical duration: _____
 Last seizure occurred on _____

Skater has a shunt Yes No

Skater has Autism
 Skater has Cerebral Palsy (CP)
 Skater has a Learning Disability
 Skater has Down Syndrome
 Skater has neck instability (alantoaxial sublexation)
 Skater has Mental Retardation *(please indicate type:)*
 Mild Moderate Severe Profound
 Spina Bifida
 Approx level _____
 Other _____

Other medical limitations/precautions *(please specify:)*

Agreement/Permission Statement:

(Words enclosed in brackets are for a parent or guardian of participants who are under age 18 and/or require such additional permission.)

I agree *[give my permission for the skater listed on this form]* to participate with Gliding Stars in weekly adaptive ice skating sessions and the Ice show at the conclusion of the program season, and to cooperate fully with those in charge of each session or event.

I agree *[give my permission for the skater listed on this form]* to be photographed, videotaped, or interviewed by any television, radio, newspaper, magazine, private person or group, and that the gathered material may be transmitted by electronic media or otherwise used in Gliding Stars published materials or in other ways for the enhancement of the Gliding Stars program.

I understand *[on behalf of the skater listed on this form]* that ice skating involves some physical risk.

NO PORTION OF THE ABOVE CAN BE CROSSED OUT OR ALTERED.

Skater Signature (if 18 or older)

Parent/Guardian Name (if skater under age 18)
 (please print)

Parent/Guardian Signature (if skater under age 18)

Date

For Gliding Stars Chapter Use Only:

Chest _____ in. Head Size: _____ in.

Waist _____ in. Outside Seam: _____ in.

Hips _____ in. Waist to Knee: _____ in.

Children
 XS S M L XL

Adult
 XS S M L XL XXL

Skate ID: _____

Paid Date _____

Check # _____ Cash Amount \$ _____
