4TH ANNUAL WOUNDED WARRIOR TENNIS CAMP

For Wounded, Ill, and Injured Service Members and Veterans
May 18 - 24, 2015 (Travel Dates: May 18 & 24)

To ensure legibility, please type your answers and be sure to answer ALL questions!

CONTACT INFORMATION:

Name of Participant as it appears on DL/passport:_____ Nickname_____

Current Mailing Address: _____ City _____ State ____ Zip _____

Permanent Address (if different from above) _____

Telephone Numbers: Home: _____ Cell: _____

Email Address: _____ Height: _____ Weight: _____ DOB: _____

Gender: ☐Male ☐Female Hometown: _____

Emergency Contacts:	**Relationship**	**Home Phone**	**Cell Phone**
(1) _____	_____	_____	_____
(2) _____	_____	_____	_____

MILITARY SERVICE INFORMATION:

Military status: ☐Active Duty ☐Veteran ☐Reservist

Branch of Service: ☐USN ☐USMC ☐USA ☐USAF Other: _____

Years of Active Duty: _____ Date of Separation from Active Duty: _____

Rank: _____ Deployment Experience: ☐OIF ☐OEF Other: _____

Were you injured post-9/11? ☐Yes ☐No

Were you injured **in combat** post-9/11? ☐Yes ☐No

DISABILITY/MEDICAL INFORMATION:

What is your disability? _____

Date of Onset: _____

Current Medications:	What are they for?	Dosage	Changes to your medications in the last 3 months?
(1) _____	_____	_____	_____
(2) _____	_____	_____	_____
(3) _____	_____	_____	_____
(4) _____	_____	_____	_____
(5) _____	_____	_____	_____
(6) _____	_____	_____	_____

DISABILITY/MEDICAL INFORMATION (cont.):

Do you have seizures? ☐Yes ☐No If yes, date of last seizure _____and type of seizure_____

Frequency of seizures:_____

Do you have diabetes? ☐Yes ☐No ☐ Type 1 ☐ Type 2

Please list any allergies you may have:

_____

Are any of your body parts susceptible to cold, heat, and /or impact? ☐Yes ☐No If yes, please list:

_____

Do you have any cardiac problems? If yes, please describe.

_____

Do you experience pain? ☐Yes ☐No

Percentage of time you are in pain: _____ On scale of 1-10, what level of pain are you in? _____

Where is your pain located? _____

Ability to speak: ☐Intact ☐Impaired

Hearing: ☐Intact ☐Impaired Hearing aids? ☐Yes ☐No

Vision: ☐Intact ☐Impaired Do you wear: glasses_____ contacts_____

Do you have any diet restrictions/ allergies? ☐Yes ☐No Please describe: _____

Do you experience any sleep disorders? ☐Snoring ☐Sleep walking ☐Sleep apnea

How many hours a night do you sleep (average)? _____

Do you have decreased strength in your upper extremities (arms)? ☐Yes ☐No If yes, what side_____

Will you need any type of adaptation device to hold racket e.g. Ace wraps/athletic tape? ☐Yes ☐No

Are you left or right hand dominant? _☐_ Left _☐_ Right

Do you have any upper extremity (arm) limitation that may affect your participation? ☐Yes ☐No

If yes, where and what extent? _____

COMBAT STRESS/PTSD/MST (Military Sexual Trauma)

Do you have panic attacks? ☐Yes ☐No

Do you have flashbacks? ☐Yes ☐No

Are you sensitive to loud noises? ☐Yes ☐ No

Do crowds make you feel anxious? ☐Yes ☐No

Do you get angry easily? ☐Yes ☐ No

Are you hyper-vigilant? ☐Yes ☐ No

Do you isolate yourself? ☐Yes ☐No

Do you get anxious easily? ☐Yes ☐No

How can we best support you should you become anxious, fearful, angry, etc?

_____

_____

_____

TRAUMATIC BRAIN INJURY (TBI)

Have you sustained traumatic brain injury? ☐Yes ☐No

Status of injury: ☐Primary Disability ☐Secondary Condition Date of injury: _____

What is the cause of your TBI? ☐Blast injury ☐Motorcycle/Vehicle accident Other_____

Do you wear a helmet? ☐Yes ☐No

Severity of Injury?: ☐Mild ☐Moderate ☐Severe

Has your TBI affected you in any if the following ways?

Short-term memory impairment ☐Yes ☐No

Decreased attention span ☐Yes ☐No

Problem-solving difficulties ☐Yes ☐No

Inability to concentrate ☐Yes ☐No

Impulsive/Decreased ability to filter what I say and/or do ☐Yes ☐No

Decreased balance ☐Yes ☐No

Vestibular impairment ☐Yes ☐No

Light sensitivity ☐Yes ☐No

Do you get dizzy? ☐Yes ☐No

Do you get motion sickness? ☐Yes ☐No

Do you have difficulty walking? ☐Yes ☐No

Do you have difficulty running? ☐Yes ☐No

Please explain the items you have checked yes to:

_____

Do you have headaches? ☐ Yes ☐ No

How often do they occur?_____ What triggers your headaches? _____

On a scale of 1 to 10, how severe are your headaches? _____

How do you treat your headaches? ☐Medication ☐Rest Other _____

MENTAL HEALTH

Do you have a mental health disorder? ☐Yes ☐No

If yes, please specify: ☐Bipolar ☐Depression ☐Adjustment Disorder ☐Schizophrenia

Other: _____

AMPUTATION

Status of Injury: ☐ Primary Disability ☐ Secondary Condition

Date of Amputation: _____ Level of Amputation: _____

Please describe your means of mobility (i.e. prosthesis, wheelchair, none, etc.)

_____

If you have prosthesis, will you be using it while taking part in our program? ☐ Yes ☐ No

DURABLE MEDICAL SUPPLIES

Do you use mobility devices? ☐Yes ☐ No If yes, which devices do you use: _____

☐Wheelchair ☐ Walker ☐ Cane ☐ Crutches ☐ Prosthetic ☐ Orthotic Other_____

Are you able to push yourself in a wheelchair? ☐Yes ☐No

Do you use a shower chair? ☐Yes ☐No If yes, will you be bringing your own? ☐Yes ☐ No

Do you need a shower chair? ☐Yes ☐ No

SPINAL CORD INJURY (SCI)

☐ Para ☐ Quad ☐Complete ☐Incomplete Are you able to transfer out of wheelchair? ☐Yes ☐ No

☐ Shunt ☐ Concerns with pressure sores/skin breakdown ☐ Concerns with muscle spasms

Please describe any other medical conditions not mentioned in any of the sections above:

_____

_____

TENNIS EXPERIENCE

Do you need to borrow a tennis wheelchair? ☐ Yes ☐ No Will you bring your own? ☐Yes ☐ No

What level of tennis do you play? ☐ Beginner ☐ Intermediate ☐ Advanced

Did you play tennis before injury or diagnoses? ☐Yes ☐No

Do you currently play tennis? ☐ Yes ☐No If yes, how many times in the last year? _____

MERCHANDISE

T-shirt size: ☐ Small ☐ Medium ☐ Large ☐ X-Large ☐ XX-Large

Tennis shoe size: _____

CARE PROVIDER (IF NEEDED) INFORMATION

Please explain why you need a Care Provider:

_____

_____

_____

Care Provider Name: _____ DOB: _____

Cell Number: _____ Email: _____

Will Care Provider be participating in the camp? ☐ Yes ☐ No

T-Shirt Size: ☐ Small ☐ Medium ☐ Large ☐ X-Large ☐ XX-Large

Tennis shoe size: _____

Will you be bringing a service animal? ☐ Yes ☐ No

Animal type: _____

Name: _____

FLIGHT INFORMATION

Departure Airport: _____ Return Airport: _____

Will you need an aisle chair? ☐ Yes ☐ No Are you travelling by yourself? ☐ Yes ☐ No

How did you learn about this camp?

_____

_____

_____

Have you participated in this camp before? ☐ Yes ☐ No ☐ 2012 ☐ 2013 ☐ 2014

Please tell us in a few sentences why you are interested in attending this camp.

_____

_____

_____

_____

Medical Clearance Form for Active Duty & Veterans

Please obtain approvals from all physicians and therapists you are seeing, as well as your Chain-of-Command if on active duty.

Applicant's Name _____ **Phone #** _____**Unit if active duty** _____

Event Name: 4th Annual Wounded Warrior Tennis Camp **Dates**: May 18-24, 2015
Location: San Diego, CA 92104
Medical POC: Marla Knox, CTRS, MA **Phone**: 619-532-5783 **Email:** marla.knox@med.navy.mil

Information about this event is available at www.sdwoundedwarriortennis.org

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PRIMARY CARE PHYSICIAN'S AUTHORIZATION

Name of Primary Care Provider _____ Phone # _____

Primary Care Provider Signature _____ Date _____

MENTAL HEALTH THERAPIST'S AUTHORIZATION

Name of Mental Health Therapist _____ Phone # _____

Mental Health Therapist's Signature _____ Date _____

RECREATION THERAPIST'S AUTHORIZATION

Name of Recreation Therapist _____ Phone # _____

Recreation Therapist's Signature _____ Date _____

PHYSICAL THERAPIST'S AUTHORIZATION

Name of Physical Therapist _____ Phone # _____

Physical Therapist's Signature _____ Date _____

CHAIN-OF-COMMAND AUTHORIZATION

Name of Officer-in-Charge _____ Phone # _____

Officer-in-Charge Signature _____ Date _____

Please provide proof of military service (one of the following three)

Copy of active duty or retired ID card
Copy of first page of DD-214
Copy of VA health system ID card

Please send the completed typed application form, medical clearance form, and proof of military service to:

Mary Alice (M. A.) Hillier
Tennis Camp Coordinator
Email: tennisma@cox.net
Fax: 619-390-5684

Please direct any questions to M.A. Her cell phone is 619-884-8911.
Please keep in mind she is in the Pacific Standard Time zone.