5TH ANNUAL WOUNDED WARRIOR TENNIS CAMP

For Wounded, Ill, and Injured Service Members and Veterans
May 15-21, 2016 (Travel Dates: May 15 & 21)

To ensure legibility, you must 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: Cell: _________________________ Home: ______________________________

Email Address: ________________________Height: _______ Weight: _______ DOB (MM/DAY/YR):_______

Gender: Male Female Hometown: ____

Emergency Contacts	Relationship	Home Phone
(1) ______________________________	________________	_______________
(2) ______________________________	________________	_______________

MILITARY SERVICE INFORMATION:

Military status: Active Duty Veteran USMC Reservist

Branch of Service: USN USA USAF Other: ___________________

Years of Active Duty: From____________to____________________Rank: ____________

Did you Serve? Operation Iraqi Freedom Operation Enduring Freedom Other: ___________

Were you injured pre-9/11? Yes No Post 9/11? Yes No

Were you injured **in combat** pre-9/11? Yes No Post 9/11: Yes No

DISABILITY/MEDICAL INFORMATION:

What is your disability? ____

Date of Onset/Injury: _________________________

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

Last Name: ______________________________

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 (Food, pets and/or other 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? 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

Are you sensitive to loud noises? Yes No

Do you get angry easily? ☐ Yes ☐ No

Do you isolate yourself? Yes ☐ No

Do you have flashbacks? Yes No

Do crowds make you feel anxious? ☐Yes ☐No

Are you hyper-vigilant? ☐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________________

Severity of Injury?: Mild Moderate Severe

____

Do you experience any of the following conditions:

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, cane, 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, do you need us to provide one in your room ☐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 tennis wheelchair? 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 XXX- Large

Tennis shoe size: _______

CARE PROVIDER (IF NEEDED) INFORMATION

What does a care provider do for you that you cannot do yourself?

____

____

____

Will the care provider be participating in the Camp Yes No

Care Provider Name:________________________ DOB (MM/DAY/YR):_________________

Cell #:____

Email Address:______________________________

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

Tennis shoe size: _______

____

Will you be bringing a service animal? Yes No

Animal type: _________________________________ Name: __________________________

FLIGHT INFORMATION

Departure Airport:_______________________ Return Airport:___________________________

Do you prefer an Aisle Seat Window Seat Will you need an aisle chair? Yes No

How did you learn about this camp?

____

____

____

Have you participated in this camp before? Yes No 2012 2013 2014 2015

Please tell us in a few sentences why you are interested in attending this camp (Required Info):

____

____

____

____

Medical Clearance Form for Active Duty & Veterans

Please obtain approvals from your primay care physician and therapists you are currently seeing, as well as your Chain-of-Command if on Active Duty

Applicant's Name: _____________________ **Cell Phone #:** ___________________ **Unit if active duty:** ____________

Event Name: 5th Annual Wounded Warrior Tennis Camp **Dates**: May 15-21, 2016 **Location**: San Diego, CA 92104
Medical POC: Mary Alice Hillier **Phone**: 619-884-8911 **Email:** tennisma@cox.net

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

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PRIMARY CARE PHYSICIAN'S AUTHORIZATION (REQUIRED)

Name of Primary Care Provider: _____________________________________ Phone #: ___________

Email Address:____

Hospital/Clinic Mailing Address: ____

Primary Care Provider Signature: ______________________________________ Date: ______________

MENTAL HEALTH THERAPIST'S AUTHORIZATION

Name of Mental Health Therapist: ___________________________________ Phone #: _____________

Email:____

Hospital/Clinic Mailing address: ____

Mental Health Therapist's Signature:______________________________ Date: ________________

RECREATION THERAPIST'S AUTHORIZATION

Name of Recreation Therapist: ______________________________ Phone #: ___________

Email:____

Hospital/Clinic Mailing address: ____

Recreation Therapist's Signature: ________________________________ Date:_______________

PHYSICAL THERAPIST'S AUTHORIZATION

Name of Physical Therapist: ________________________________ Phone #: _______________

Email:____

Hospital/Clinic Mailing address:____

Physical Therapist's Signature: _________________________________ Date: _________________

CHAIN-OF-COMMAND AUTHORIZATION (if Active Duty) :

Name of Officer-in-Charge: _________________________________ Phone #: ___________

Email:____

Mailing address: ____

Officer in Charge Signature:__________________________________ Date: _________________

Last Name: ______________________________

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

Copy of Military ID card
Copy of first page of DD-214
Copy of VA health system ID card

In addition provide copy of picture ID card (Driver License or State 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

Please direct any questions to Mary Alice. Her cell phone is 619-884-8911.
Please keep in mind she is in the PACIFIC STANDARD TIME ZONE (CA).

Place picture ID cards below and email with complete
application and medical clearance form (Total of 7 Pages)

Place Here