the YMCA

RAPPAHANNOCK AREA YMCA

Applicant Information

Thank you for your interest in our Spectrum Sea Turtles Aquatic Program (SSTAP)! We will be continuing to grow every day to meet the needs and safety of our members. Your input here is essential to the formulation of our program. To begin, please complete the application below and email to jared@fusionpta.com.

Date ____/____/____

Name _____ DOB _____/_____/_____

Address _____

City _____ Zip Code _____

Home phone _____Cell phone _____

Business Phone _____Email _____

How did you hear about SSTAP (circle)? Referral / Media /Website / Support or Community Group/Other_____

Emergency Contact Information

Name _____

Relationship to applicant_____

Address _____

City _____ Zip Code _____

Home phone _____Cell phone _____

Email _____

Neurological Disorder Information:

Name of neurological disorder_____

Estimated date of diagnosis ____/____/____

Which symptoms are you experiencing? (check all that apply and describe in the space below)

Behavioral Challenges

- ☐ **Inappropriate Social Interactions**
- ☐ **Poor Eye Contact**
- ☐ **Compulsive Behavior**
- ☐ **Impulsivity**
- ☐ **Repetitive Movements**
- ☐ **Self-Harm**
- ☐ **Echolalia**

Developmental Challenges

- ☐ **Speech Delay**
- ☐ **Learning Delay**
- ☐ **Physical Delay**

Cognitive Challenges

- ☐ **Selective Interests**
- ☐ **ADD**
- ☐ **ADHD**
- ☐ **ODD**

Psychological

- ☐ **Anxiety**
- ☐ **Depression**
- ☐ **Sound Sensitivity**
- ☐ **Light Sensitivity**
- ☐ **Other_____**

☐ **Other Comorbidities**_____

Please Explain:

_____

_____

_____

_____

_____

Medication List:

_____ _____ _____

_____ _____ _____

Communication Preference

Do you prefer (check all that apply):

- ☐ **English Language Speaking**
- ☐ **PECS**
- ☐ **EReader or Language App**
- ☐ **American Sign Language**

AHA/ACSM Health/Fitness Facility

Pre-Participation Screening Questionnaire

Medically-Based Fitness

History: (check all that apply)

You have had:

- ☐ **A heart attack**
- ☐ **Heart surgery**
- ☐ **Cardiac catheterization coronary**
- ☐ **Angioplasty (PTCA)**

- ☐ **Pacemaker/implantable cardiac defibrillator**
- ☐ **Rhythm disturbance**
- ☐ **Heart valve disease**
- ☐ **Heart failure**
- ☐ **Heart transplantation**
- ☐ **Congenital heart disease**
- ☐ **Other heart condition (specify) _____**

Symptoms:

- ☐ **You experience chest discomfort with exertion**
- ☐ **You experience unreasonable breathlessness**
- ☐ **You experience dizziness, fainting or blackouts**
- ☐ **You take heart medications**

Other health issues:

- ☐ **You have diabetes**
- ☐ **You have asthma or other lung disease**
- ☐ **You have burning or cramping sensation in your lower legs when walking short distances**
- ☐ **You have musculoskeletal problems that limit your physical activity**
- ☐ **You have concerns about the safety of exercise**
- ☐ **You take prescription medication(s)**
- ☐ **You are pregnant**

Notes and Other Questions

What symptoms of Autism/Neurological Disorder are you experiencing in your daily life?

_____

_____

Have you been diagnosed with any other medical problems we should be aware of?

_____

_____

What do you wish to gain from joining SSTAP?

_____

_____

Are you currently active on social media? Yes/No

Are you willing to leave reviews online and on social media? Yes/No

Are you willing to continue with the program at our regular rate ($80 per month) after the Voucher is expired? Yes/No

Do you have questions or concerns about the program before we get started?

Additional notes or questions:

_____

_____

_____

_____

_____

_____

Signature

I _____ (member name) allow SSTAP to review my application for entry into the program. All the provided information is true to the best of my knowledge.

Signature _____Date _____

Signature of guardian_____Date_____

(if applicant is under age 18)