

Personal Information

First Name:

Preferred Name

Middle Name:

Last Name:

Date of Birth:

Gender

**Current Street
Address:**

City:

State:

Zip:

Cell Phone:

Home Phone:

Work Phone:

E-mail Address

Alternate E-mail:

Height::

Weight:

Shirt Size

Shirt Cut:

Branch of Service:

- | | | |
|------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Air Force | <input type="checkbox"/> Coast Guard | <input type="checkbox"/> National Guard |
| <input type="checkbox"/> Army | <input type="checkbox"/> Marines | <input type="checkbox"/> Navy |

Rank:

- Active Duty
- In Medical Board Process
- Discharged and/or Retired

**Who Referred you?
Name and/or
Organization:**

**Have you participated
in any trips or events
for injured military?**

- Yes
- No

**If yes, how many and
with what
organizations?**

Medical Information

Date Injured:

Iraq

United States

Afghanistan

Injury/Disability

Injury/Disability

TBI

Visual Impairment

Spinal Cord Injury

Amputation

Burns

Disfigurement

Post Traumatic Stress

How were you injured?

**Any recent surgeries
and/or revisions?**

**Do you have a history
of the following?**

- | | |
|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> None |

**Any reason to limit
your participation in
physical activity**

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

Please list any medications you are currently taking (dosage & reason):

History of Seizures?

Yes

No

If you have a history of seizures, do you know when you are going to have one?

Yes

No

Do you have a service animal?

Yes No

If you have a service animal, will the animal be attending the camp?

Yes No

If you are bringing your service animal, please list animal's name, breed and the organization you received your animal from.

Do you have any food allergies and/or dietary restrictions?

Yes No

If yes, please list:

Do you have any non-food allergies?

Yes

No

If yes, please list:

Travel Information

Spelling of your name on your identification card:

Departure City

Nearest Airport(s)

Guest Information

Name:

Relationship

Date of Birth

Current Address:

City

State

Zip

Cell Phone:

Home Phone:

Work Phone:

E-mail

Alternate E-mail

Gender

Shirt Size

Yes

No

If no, what departure city/nearest airport?

Does your guest have any food allergies and/or dietary restrictions?

Yes

No

If yes, please list:

Does your guest have any non-food allergies?

Yes

No

If yes, please list:

Yes

No

If yes, please list:

Emergency Contact & Insurance Information

**Primary Emergency
Contact:**

Relationship:

Phone Number:

**Secondary Emergency
Contact:**

Relationship:

Phone Number:

**Physician's Phone
Number**

**Medical Insurance
Provider:**

I understand that Lakeshore Foundation is an alcohol-free campus. I will not bring, purchase or consume any alcohol during Operation Alpha. Any violation of this policy is subject to immediate dismissal and removal from Operation Alpha.

**Agree to the above
statement**

Yes

I certify that the above information is accurate and I meet the qualifying criteria to attend Operation Alpha. I understand by submitting this application I will undergo an interview to review my application and may be asked to verify any information provided in this form. In addition, I recognize this is a sport and recreational opportunity and my guest and I will be expected to fully participate in scheduled activities. All applications are accepted on a first-come, first-serve basis. I acknowledge that in submitting this application that I am not guaranteed to attend Operation Alpha.

**Understand the above
statement**

Yes