



FORM B - SPECIAL CONDITIONS INFORMATION FORM

NAME OF PARTICIPANT _____

PLEASE CHECK

CONDITION		NO	YES
	This section is to be completed by a parent, guardian, caregiver, counselor, physician, physical therapist, occupational therapist or education/teacher who is familiar with the ability level and limitations of the participant		
1	VISUAL OR HEARING IMPAIRMENT		
2	DIFFICULTY IN COMPREHENDING INSTRUCTIONS		
3	SEVERE ALLERGIES (EPINEPHRINE REQUIRED)		
4	DEVELOPMENTALLY DELAYED		
5	ATTENTION DEFICIT DISORDER		
6	ASTHMATIC (prone to attacks)		
7	PROSTHESIS		
8	LIMITED RANGE OF MOTION DUE TO INJURY, SURGERY, OR OTHER <i>Specify</i>		
9	ANY OTHER CONDITION THAT IS NOT ALREADY LISTED AND SHOULD BE DISCLOSED <i>Specify</i>		
<i>Form completed by (print name):</i> _____ <i>Signature:</i> _____ <i>Relationship to participant:</i> _____ <i>Date:</i> _____			
CONDITION		NO	YES
	This section must be completed by a physician, physical therapist, occupational therapist, or person qualified to conduct functional assessments of the participant		
1	SPINA BIFIDA		
2	CEREBRAL PALSY		
3	MUSCULAR DYSTROPHY		
4	HYDROCEPHALUS (SHUNT)		
5	VISUAL IMPAIRMENT		
6	POLIO		
7	AUTISM		
8	PREDISPOSITION TO SEIZURES		
9	USHER'S SYNDROME		
10	ANY OTHER CONDITION THAT COULD RESULT IN POSSIBLE LIMITATIONS DURING PARTICIPATION IN A GYMNASTIC CLASS <i>Specify</i>		
11	DOWNS SYNDROME - If yes, please complete atlanto-axial section		
<i>Form completed by (print name):</i> _____ <i>Signature:</i> _____ <i>Relationship to participant:</i> _____ <i>Date:</i> _____			