Dear Veteran,

VA Boston Healthcare System in partnership with Providence VAMC will be hosting the 2021 New England Summer Sports Clinic in Providence Rhode Island, July 19th through the 23th, 2021. To participate please read through the application packet and complete. This event promotes rehabilitation by instructing Veterans with disabilities in adaptive sports.

WHO is eligible to participate?

Participation is open to male and female military service veterans with spinal cord injuries, orthopedic amputation, visual impairments, neurological problems, and other disabilities. The application includes a general medical information section. All applications are reviewed by the Summer Sports Clinic's program directors and medical officer. Their decisions are final.

- Veterans who are enrolled in VA Healthcare
- ***FULLY*** completed applications
- Preference will be given to first time participants to the New England Summer Sports Clinic
- Applications received by the deadline (May 15th, 2021)
- Compliance with Participant Agreement.

WHAT is the weekly schedule like, and what activities do we participate in?

- ✓ July 19 - Registration, Team Assignments, Golf Expo, Opening Reception, Team Meetings
- ✓ July 20 - Sailing, Cycling, Kayaking, Surfing
- ✓ July 21 - Sailing, Cycling, Kayaking, Surfing
- ✓ July 22 – Deep Sea Fishing or Beach Day!, Awards Banquet
- ✓ July 23 - Check Out

This is a tentative activity schedule and is subject to change.

Prior to the Summer Sports Clinic, you will be assigned to a team. Your team leader will contact you and will answer any questions you may have.

As a participant, you will work with adaptive instructors and adaptive equipment. Your instructor will assess your abilities and adapt the training program to meet your needs. Activities are scheduled from approximately 8:00am to 4:00pm which are team based and require **ALL** members to be present and participate at their highest level.

WHERE is the Summer Sports Clinic held?

This year's Summer Sports Clinic for Disabled Veterans will be held in Rhode Island. VA Boston Healthcare System and Providence VAMC will be working with community partners throughout New England to bring you this exciting rehabilitation event. Once accepted you will be required to call the hotel and provide them with a credit card number to pay for your room. You are responsible for your room charges for the week and must have a credit card on file while staying with the hotel for any incidental expenses. Hotel information will be provided upon acceptance into the clinic.

Please fill out the **Hotel Accommodation** portion of the application completely. Space is limited. All events are nearby and wheelchair accessible transportation is provided.

Registration is held at the hotel between the hours of 8:00 a.m. and 11:00 a.m. on Monday July 19, 2021 as activities will begin at noon.

HOW do I apply?

Veterans can apply to participate by completing all elements of the registration packet. **Only fully completed applications received by May 15th, 2021 will be accepted.**

Mail your complete application to:

Jenny Vulpis
VA Boston Healthcare System
940 Belmont Street (BR 135)
Brockton, MA 02301

You will be notified that your application has been received **no later than June 1st, 2021**. Once all applications have been reviewed a selection letter will be sent to you no later than July 1st, 2021.

WHAT is included?

Veterans are expected to pay for their room charges as well as transportation to and from the Summer Sports Clinic. The hotel will offer a continental breakfast each morning. Lunches will be provided free of charge Monday through Thursday. In addition, dinner is provided Monday through Thursday. Meals are all done through sponsors, and menus are unknown at this time. All equipment and related clinic activities are free of charge.

WHAT if I need medical care?

A VA physician and registered nurse make up our onsite medical team. **If you need daily supportive care or assistance in activities of daily living then you must arrange for your own support personnel.** Evidence of your own adequate ADL assistance for bathing, showering and catheter/bowel care is required. We recommend that if you anticipate needing personal equipment or supplies such as catheters, leg bags, irrigating solutions, and shower chairs, etc. that you bring these items with you.

BRING ALL NECESSARY MEDICATIONS WITH YOU.

WHAT else should I bring?

- ✓ A bathing suit for the pool and lake activities.
- ✓ Waterproof outerwear that is designed for rain conditions.
- ✓ Appropriate clothing for warm weather days and cool nights.
- ✓ Sunglasses and sunscreen are helpful.
- ✓ Your team leader can help you decide what clothing to bring.

COVID 19 Statement:

We are continually monitoring the COVID-19 virus when planning for the 2021 New England Summer Sports Clinic and potential changes we may need to make to keep everyone safe. More information will become available as we get further into 2021 and will be shared.

All information must be provided for application to be considered.

SECTION I: CONTACT INFORMATION

Participant Name: _____

Date of Birth:_____ **Full Social Security Number:** _____

Street Address:_____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____ **Cell Phone Number:** _____

E-Mail Address: _____

Branch of Service: _____

Are you a member of any service organization? (NEPVA, DAV, etc)If yes, which one(s):

_____

IN CASE OF EMERGENCY, NOTIFY:

Name: _____

Daytime Phone: _____ **Evening Phone:**_____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Relationship to patient: _____

T-shirt Size (circle one): Small Medium Large X-Large 2XL 3XL

Participant Agreement:

This event is an extension of VA health care. Compliance with VA regulations and policies is mandatory for all participants. Bringing weapons, non-prescribed drugs or paraphernalia, unexcused non-participation, exhibiting disruptive behavior and harassment of others in any form, will not be tolerated and may result in immediate expulsion and may affect future participation.

I acknowledge that participating in this event is a potentially hazardous activity, but represent that I am trained adequately and am medically able. I agree to assume all risks associated with this event, including but not limited to serious bodily injury, including death, and property damage. Participant consents to medical treatment in the case of emergency and agrees to assume full responsibility for payment of any and all fees incurred as a result of medical treatment.

Participant agrees to assume any liability and expense incurred as a result of property damage arising from negligence or intentional misconduct of participant or their guest.

Participant Signature:_____ **Date:** _____

SECTION II: HOTEL ACCOMMODATION

Will you be requesting hotel accommodations?	❑ YES	❑ NO
Would you be willing to share a room?	❑ YES	❑ NO
Will you be bringing a Service Animal?	❑ YES	❑ NO
Will a caregiver be attending with you?	❑ YES	❑ NO

If you have a roommate preference, list their name below so that we can maximize the rooms available.

Roommate's Name: _____

Are you bringing family member(s) or a caregiver? If yes, please provide their name(s) and ages if under the age of 18 years old: _____

_____

Once your application has been reviewed and you have been accepted you will need to contact the hotel to provide a credit card number for payment. The hotel contact information will be provided in the acceptance letter.

SECTION III: GENERAL INFORMATION/ALTERNATE ACTIVITIES

Mobility level:

- ❑ Ambulatory
- ❑ Cane
- ❑ Manual Wheelchair
- ❑ Standing visually impaired
- ❑ Other
- ❑ Non-ambulatory
- ❑ Walker
- ❑ Power wheelchair/scooter
- ❑ Sitting visually impaired

Are you planning on bringing your own equipment necessary for your sport? ❑ Yes ❑ No

If yes, what type of equipment will you bring? _____

Have you attended the New England Summer Sports Clinic in the past? If yes, what years?

- ❑ 2010
- ❑ 2011
- ❑ 2012
- ❑ 2013
- ❑ 2014
- ❑ 2015
- ❑ 2016
- ❑ 2017
- ❑ 2018
- ❑ 2019
- ~~❑ 2020~~

SECTION IV: GENERAL MEDICAL EXAMINATION

TO BE COMPLETED BY EXAMINING CLINICIAN

To Clinicians: Your patient is planning on participating in an outdoor rehabilitative sporting event that takes place at various areas in Rhode Island in July. Please assist us in ensuring that applicants are appropriate for this rehabilitative activity by conducting a detailed review of your patient's medical record. All activities are done in a supportive environment to ensure positive outcomes and safety. Should you have questions regarding this event and the activities please feel free to call or email Jenny Vulpis, 774-826-1955, or email: jenny.vulpis@va.gov

Patient's Name: _____ Date: _____

Social Security Number: _____ Date of Birth: _____

VAMC where patient receives care: _____

SECTION IV a: DIAGNOSIS

Primary Diagnosis/Type of Injury (Date of Onset: _____)

❑ Spinal Cord Injury Level _____ Complete _____Incomplete

❑ Multiple Sclerosis

❑ Ataxia/ other neurological conditions

❑ Traumatic Brain Injury

❑ CVA with residual

❑ Amputee: Leg: Right Left A/K B/K

Arm: Right Left A/E B/E

❑ Mental Health diagnosis: _____

❑ Other: _____

Hearing Impairment Diagnosis

Which ears are affected? ❑ Right ❑ Left ❑ Both

Does patient use hearing aids? Yes No

Visual Impairment Diagnosis

If applicable, circle:

Legally Blind (best corrected <20/200 ou) Field Loss Totally Blind

Which eyes are affected?: ❑ Right ❑ Left ❑ Both

Can patient see with glasses?: Yes No

Other visual problems (specify): _____

Patient's Name: _____ Date: _____

SECTION IV b: HISTORY

Medical History: Please check all boxes that apply.

Has your patient ever had or currently having problems with:

- ❑ Anxiety/Panic Disorders
- ❑ Readjustment issues since combat
- ❑ Chronic pain requiring narcotics
- ❑ PTSD
- ❑ Drug/Alcohol Use
- ❑ Asthma
- ❑ Anticoagulation
- ❑ Hypoxia requiring O_2
- ❑ Coronary Heart Disease
- ❑ Difficulty with Behavior/Emotions
- ❑ Dysreflexia (autonomic)
- ❑ Diabetes
- ❑ COPD
- ❑ Seizures
- ❑ Communication Deficits/Aphasia

Allergies: _____

Current Medications: _____

Other Remarks: _____

Patient's Name: _____ Date: _____

SECTION IV c: PHYSICAL EXAMINATION

Height: _____ Weight: _____

Pulse: _____ Blood Pressure: _____ Heart: _____

Lungs: _____ Head & Neck: _____ Abdomen: _____

Extremities _____

Sitting Balance: Normal Fair Poor

Does the patient smoke? Yes No

Does this patient require a caregiver/attendant? Yes No

Do they use a wheelchair for mobility? Yes No

What other adaptive equipment do they use? _____

_____

In your professional opinion, the above applicant is: (PLEASE CIRCLE ONE)

CLEARED TO PARTICIPATE **NOT CLEARED TO PARTICIPATE**

Signature of Examining Clinician: _____

Please Print Clinician's Name: _____

Phone: _____ **Pager Number:** _____

Should you have questions regarding this event and the activities please feel free to call or email: Jenny Vulpis, 774-826-1955 or jenny.vulpis@va.gov

Department of Veterans Affairs

CONSENT FOR PRODUCTION AND USE OF VERBAL OR WRITTEN STATEMENTS, PHOTOGRAPHS, DIGITAL IMAGES, AND/OR VIDEO OR AUDIO RECORDINGS BY VA

NAME OF INDIVIDUAL WHOSE STATEMENT, LIKENESS, OR VOICE IS REQUESTED

NOTE: The execution of this form does not authorize production or use of materials except as specified below. The specified material may be produced and used by VA for authorized purposes identified below, such as education of VA personnel, research activities, or promotional efforts. It may also be disclosed outside VA as permitted by law and as noted below. If the material is part of a VA system of records, it may be disclosed outside VA as stated in the “Routine Uses” in the "VA Privacy Act Systems of Records" published in the Federal Register.

The purpose of this form is to document your consent to the Department of Veterans Affairs' (VA) request to obtain, produce, and/or use a verbal or written statement or a photograph, digital image, and/or video or audio recording containing your likeness or voice. By signing this form, you are authorizing the production or use only as specified below.

You are NOT REQUIRED TO CONSENT TO VA's REQUEST to obtain, produce, and/or use your statement, likeness, or voice. Your decision to consent or refuse will not affect your access to any present or future VA benefits for which you are eligible.

You may rescind your consent at any time prior to or during production of a photograph, digital image, or video or audio recording, or before or during your provision of a verbal or written statement. You may rescind your consent after production is complete if the burden on VA of complying with that request is not unreasonable considering the financial and administrative costs, the ease of compliance that number of parties involved, and _____ *(To Be Completed by the VA).*

THE PHOTOGRAPH, DIGITAL IMAGE, AND/OR VIDEO OR AUDIO RECORDING WILL BE PRODUCED WHILE I AM *(describe the activity or situation)* ***(To Be Completed by the Department of Veteran Affairs, if applicable)***

Participating in the New England Summer Sports Clinic in Rhode Island July 19-23, 2021. The events of the week will be golfing, cycling, kayaking, sailing, surfing, fishing, archery. Please note some of these activities are subject to change.

CHECK AT LEAST ONE OF THE FOLLOWING ***(to be completed by VA)***

☒ I hereby voluntarily and without compensation authorize VA Boston Healthcare System
NAME OF FACILITY

to produce a photograph, digital image, and/or video or audio recording of me *(or of the above named individual if the individual is legally unable to give consent).*

☒ I hereby voluntarily and without compensation authorize VA Boston Healthcare System
NAME OF FACILITY

to obtain or use a verbal or written statement from me *(or the of the above named individual if the individual is legally unable to give consent).*

I consent to allowing VA to record and use a verbal or written statement, or produce and use photographs, digital images, and video or audio recording for the purpose(s) identified below:

This product will be used: *(NOTE: At least one of these boxes must be checked as well as a purpose described below) (to be completed by VA)*

☒ Internally *(stay within VA)* ☒ Externally *(shared outside VA)*

PLEASE CHECK THE APPLICABLE PURPOSE(S) ***(to be completed by VA)***

PROMOTIONAL EFFORTS:

☒ Internal Publication *(only VA)* ☒ External publication *(publicly available)*

☒ Other *(Specify)*:

Facebook, Twitter, Instagram, Flickr, Youtube

RESEARCH ACTIVITIES: ☐ Study

EDUCATION PURPOSES:

☒ Presentation ☒ Conference ☐ Publication in a Journal ☒ Training

☐ Other *(Specify)*:

VA ONLY USE:

☒ Performance Improvement ☒ Quality Improvement ☐ Health Care Operations

☐ Other *(Specify)*:

☒ All of the Above

NOTE: Do not sign this form unless one or more of the boxes above has been checked.

I have read and understand the foregoing, and I consent to the use of a verbal or written statement from me, and/or of my likeness and/or voice as specified for the above-described purpose(s). I understand that no royalty, fee, or other compensation of any kind will be made to me by the United States for such use. I understand that consent to obtain, produce, and/or use a verbal or written statement, photograph, digital image, and video or audio recording containing my likeness or voice is voluntary, and my refusal will not adversely affect my access to any present or future VA benefits for which I am eligible. I further understand that I may, at any time, rescind my consent prior to or during production of a photograph, digital image, or video or audio recording. I also understand that I may rescind my consent after production is complete if the burden on VA of complying with that request is not unreasonable considering the financial and administrative costs, the ease of compliance, and the number of parties involved.

PRINT FULL NAME *(First and Last Name)*	SIGNATURE	DATE *(MM/DD/YYYY)*

PERMISSION OBTAINED BY ***(TO BE COMPLETED BY VA)***

Jenny L. Vulpis	Adaptive Sports Case Manager	02/03/2021
PRINT EMPLOYEE FULL NAME	TITLE	DATE *(MM/DD/YYYY)*

SIGNATURE OF PERSON OBTAINED OBTAINING CONSENT ***(TO BE COMPLETED BY VA)***

Jenny L. Vulpis	Jenny L Vulpis 178670 Digitally signed by Jenny L Vulpis 178670 Date: 2021.02.11 14:58:48 -05'00'	02/03/2021
PRINT EMPLOYEE FULL NAME	SIGNATURE	DATE *(MM/DD/YYYY)*

IMPORTANT: If VA is providing or releasing any patient health or demographic information with the verbal or written statement, photograph, digital image, or video or audio recording, VA Form 10-5345, Request for and Authorization to Release Medical Records or Health Information, is required prior to the release of such data to any source outside VA.