



## LOCALS' SEASON PASS APPLICATION

NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

All information on this application must be submitted fully and accurately in order for your season pass to be approved. Please note, proof of residency (utility bill, lease, etc.), along with proof of your **permanent disability** (please see attached Medical Release) must be submitted with this application each year you apply. Furthermore, all Challenge Aspen waivers **MUST** be signed prior to picking up your pass. If you have any questions, please contact Rachel Huntoon. [rachel@challengeaspen.com](mailto:rachel@challengeaspen.com) OR 970-923-0578 Ext. 208

### PERSONAL CONTACT INFORMATION

Home Address:

\_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Mailing Address (if different from above):

\_\_\_\_\_  
\_\_\_\_\_

Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address:

\_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

### DISABILITY INFORMATION

Please state your disability & why you are applying for a local's pass:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe any other medical conditions you feel as though we need to know about:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any seizures in the last two years? Yes \_\_\_ No \_

### TICKET PICK UP INFORMATION

At which ticket window/season pass office will you be picking up your pass? \_\_\_\_\_



## MEDICAL RELEASE For Challenge Aspen Local's Season Pass

Winter recreational activities with Challenge Aspen are physically oriented and all involve a level of inherent danger. Prior to taking part in Challenge Aspen programs, we require that each participant have physician's approval in order to ensure the safety of each individual.

### PERMISSION TO PARTICIPATE IN CHALLENGE ASPEN PROGRAMS:

The release below must be signed by the participant's physician before they can be approved for a Local's Season Pass.

Your patient, \_\_\_\_\_, has applied for a Local's Disability Season Pass. Are there any medical factors in your patient's history that would affect his or her ability to safely participate in this non-medically supervised program?

**YES**

**NO**

If yes, please list and explain:

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Patient's Disability Information:

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Please identify any recommendations or restrictions that are appropriate for your patient:

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My patient, \_\_\_\_\_, has my approval to take part in Challenge Aspen adaptive recreation programs with the restrictions and/or recommendations stated above.

Physician name (please print): \_\_\_\_\_

Physician signature: \_\_\_\_\_

Work phone: \_\_\_\_\_

Date: \_\_\_\_\_