

COURAGE KENNY SKI & SNOWBOARD PROGRAM

COURAGE KENNY SKI & SNOWBOARD MANUAL

Courage Kenny Rehabilitation Institute
Sports & Recreation Department

Updated Fall 2015



THE MISSION AND VISION OF COURAGE KENNY REHABILITATION INSTITUTE

Mission Statement: Courage Kenny Rehabilitation Institute maximizes quality of life for people of all ages and all abilities. We help people achieve health and wellness by offering excellent services, innovative programs, ground-breaking research and barrier-shattering advocacy.

Vision Statement: We are guided by our vision that one day all people will live, work, learn and play in a community based on abilities, not disabilities.

WELCOME TO COURAGE KENNY SKI AND SNOWBOARD PROGRAM

One of the largest adaptive ski and snowboard programs in the country, Courage Kenny Ski and Snowboard program (CKSS) provides more than 1,200 lessons per year at seven sites across Minnesota and Wisconsin and is supported by 380 volunteer instructors. Our lesson formats and teaching techniques are consistent with Professional Ski Instructors of America Adaptive standards.

Originating as the Minnesota Handicapped Skiers Association at Welch Village, near Hastings Minnesota, in 1968, the program has provided one-on-one adaptive skiing instruction and winter recreation opportunities to people of all ages, abilities and backgrounds for more than 40 years. During these years, we have seen participant and volunteer numbers grow significantly and we have developed new program elements, teaching styles and training programs. Our instructor's skills and expertise, our inventory of specialized equipment, and longstanding relationships with local ski areas enable us to meet a variety of client needs.

Participants range from 6 to 60+ years of age with disabilities including: Cerebral Palsy, Traumatic Brain Injury, Spinal Cord Injury, Spina Bifida, Stroke, Autism, Visual Impairments, and many other disabilities.

Locations Include

Afton Alps

Giants Ridge

Hyland Ski and Snowboard Area

Lutsen Resort

Welch Village

Theodore Wirth Park (Nordic skiing)

Trollhaugen

Spirit Mountain

Thank you for volunteering your time and talents.

YOUR ROLE AS A VOLUNTEER

As a volunteer ski instructor for the CKSS program, you are assuming many responsibilities. Most instruction is one-to-one, so it is very important that you are prompt and are at the ski area, prepared to teach, on those days you are scheduled to do so. If you know ahead of time that you will not be able to attend one day, you are responsible for finding your own substitute. If you must be absent due to illness or emergency, please notify the program coordinator as early as possible.

To help insure the safety of your student, please familiarize yourself with your student's disability. Further on in this manual is a discussion on the disabilities most frequently seen in the students partaking in the program. Please read this section thoroughly. If you have any questions, please contact the ski line for further information.

CONFIDENTIALITY

All information regarding individual skiers is confidential and their rights of privacy must be carefully observed at all times. Feel free to discuss your volunteer experience with others, but please, **no identifying information.**

Weather Policies

Programming will be canceled when the temperature is expected to be colder than 5 below zero (air temperature) and/or 10 below zero wind-chill. Cancellation decisions are made each program day based on local weather reports and other factors. It's each participant's and volunteer's responsibility to call the Ski Hotline to verify if program is running or cancelled.

Metro Ski Hotline: 612-775-2282

A message will be recorded by 7pm on the day before for weekend programs (Saturday, Sunday) and at 12pm for weekday programs (Monday, Wednesday) on the Metro Ski Hotline 612-775-2282.

Northland Ski Hotline: 218-726-4834 ext. 1.

A message will be recorded by 3:00pm on the Courage Kenny Northland Ski Hotline at 218-726-4834 ext. 1.

Courage Kenny SKI and SNOWBOARD PROGRAM COORDINATORS

Megan Welty, Twin Cities Programs 612-775-2280 megan.welty@allina.com
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Tara Gorman, Northland 218-726-4834 tara.gorman@allina.com
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VOLUNTEER COORDINATOR

Lisa Lauzon, Northland 218-726-4763 lisa.lauzon@allina.com
Mari Salvesson, Twin Cities Programs 612-775-2729 mari.salvesson@allina.com

Courage Kenny Ski and Snowboard Volunteer Position Description

- Position Title:** Ski and Snowboard Program Volunteer
- Department:** Sports and Recreation, Courage Kenny Northland
Sports and Recreation, Courage Kenny Metro
- Location:** Spirit Mountain, Giant's Ridge, and/or Lutsen Mountain
Hyland Hills, Afton Alps, Welch Village and Trollhaugen
- Objective:** To help provide ski or snowboard instruction to children and adults with disabilities
- Supervised by:** Program Site Coordinator
- Term of Appointment:** One season minimum

Time Commitment:

Mid December through March, excluding inclement weather
Specific program days and times vary between program sites

Required trainings:

- ❖ **Dryland Volunteer Orientation Classroom:** TBD
- ❖ **On hill trainings:** TBD.

Responsibilities:

- To work weekly with a designated skier or snowboarder.
- To obtain and return necessary adaptive ski equipment
- To ensure safety before, during and after skiing.
- To give encouragement and positive reinforcement to student when appropriate.
- To promote a fun outdoors experience.
- Assist with all equipment set up and take down
- Proper documentation of lesson.

Competencies:

- Intermediate to advanced skiing/snowboarding ability
- Desire to teach skiing/snowboarding to individuals with disabilities
- Provide own ski/snowboard equipment
- See other skills needed for specific volunteer instructor levels below

For schedule changes or weather cancellations call your ski hotline. Leave a message if you are unable to attend your session.

Volunteer Instructor Job Requirements/Descriptions:

Lead Trainer: A volunteer that exhibits exceptional leadership and knowledge. Shows exceptional skill in training instructors chosen to represent their discipline in order to make informed decisions on the technical aspects of teaching and on the volunteer training model. Responsibilities include off-season planning meetings prior to training season to organize trainers, teaching at least one education opportunity, and being available on the hill as a technical authority. Lead trainers meet throughout the year, to help shape the training. Lead Trainers are allowed to train and check instructors off outside of OTH as needed. Lead Trainers create training schedule for OTH in order to most optimally cover all the different areas within each discipline. There should be at least one lead trainer represented at each program time/site, from each discipline area.

Prerequisite:

- has been a trainer for at least 2 years, exceptions can be made at Program Coordinator's Discretion (e.g. Individual has trained/taught at another adaptive program).
- strong understanding of the technical aspects of adaptive skiing
- strong organization and communication skills

Trainer: A volunteer instructor that leads On-the-Hill training clinics for new and returning volunteer instructors. Has good communication skills, is knowledgeable about adaptive terminology for skiing and/or snowboarding, can teach to a variety of learning styles and has demonstrated leadership to site coordinators, current trainers, and other instructors. These individuals are able to address each of the sections noted on the evaluation form, are able to demonstrate the necessary skills, and provide appropriate feedback to instructors in order to improve skills and knowledge of individual instructor's capabilities and limitations.

Prerequisite:

- An instructor for at least 2 years (exception will be made on an individual basis).
- Able to Ski or Ride at a Level 6 or above using PSIA criteria.
- Recommended by Site Coordinator, Trainer, or Program Coordinator
- Able to attend the TTT event at least once every 2 years.
- Current active instructor.

Lead Instructor: A volunteer who possesses the required skills to independently lead a safe and effective lesson to a participant in the program with minimal support from an assistant, buddy or volunteer of equal or lesser skill. This instructor must pass the Courage Kenny training evaluation for their discipline area, be comfortable creating lesson plans and able to execute all the necessary techniques.

Prerequisite:

- Generally, has taught at least 1 year in the program
- Skis or rides at an intermediate or advanced level.
- Able to tether and/or perform hands on techniques safely.

Instructor Assistant: Someone that has completed the CKRI ski and/or snowboard training, and was evaluated to possess satisfactory skills in most areas but is lacking experience and or confidence to execute all the skills necessary on a consistent basis. This volunteer will assist the lead instructor in the lessons helping to load and unload equipment on chairlifts, they will ski behind the participant and instructor to provide a safe environment, and is continuing to develop tethering skills beyond the beginner terrain. This skill development must be under the supervision of the lead instructor.

Buddy: Someone that has completed the CKRI ski and snowboard training. This volunteer's role will be focused on motivating the student, carrying extra equipment, and helping provide a safe lesson by providing an 'umbrella of safety' around lesson. This volunteer will not be able to tether, but can help lift and load equipment. Continuing education and evaluation is required to develop skills necessary to become an assistant instructor (i.e. tethering skills).

Reevaluation: Volunteers can work on improving their skills and be reevaluated throughout the winter by attending the educational opportunities throughout the season. They will have an opportunity to get re-evaluated during the season by scheduling a time with the Program Coordinator or Directors of Instruction and running through skills that need improvement with a Trainer at their site. Improved skills need to be noted on their evaluation form with an initial by the Program Coordinator and evaluating trainer.

Required Trainings:

New Instructors:

- Dryland Training

- Must attend 2 days of On the Hill Training in their discipline

Returning Instructors

- Must attend 1 day of On the Hill Training in their discipline

Evaluation Form Criteria:

FUNCTIONAL SKI/RIDE

Side Slip to Hockey Stop:

This maneuver is extremely important as a method used in tethering mono or bi-skis, guiding blind students or working with any other disability.

1. From a straight run in the fall line, initiate a sideslip through simultaneous turning of both legs across the fall line while maintaining a stable upper body and balanced/neutral stance.
2. A natural lead of the uphill ski and body keeps hips free to adjust edge angles.
3. After a distinct side slip, progressively tip both feet and legs into the hill to engage edges to a balanced stop. It should not take more than 15' to accomplish a complete stop and should be able to be executed within a corridor of approximately 2.5 ski lengths.
4. Continuous adjustment from foot-to-foot will help center skier over both skis.

Hockey Stop:

Used as a means to emergency stop a student in equipment swiftly.

1. Simultaneous turning of both legs across the fall line while maintaining a stable upper body and balanced/neutral stance.
2. A natural lead of the uphill ski and body keeps hips free to adjust edge angles.
3. While increasing edge angle stopping should happen quickly.

Parallel Turning

Freely on groomed blue terrain

1. Linking turns at a minimum of dynamic parallel or *disability equivalent*
2. Using ski design and skill blend, appropriate to terrain and conditions.
3. Maintaining a balanced and centered stance.
4. Using progressive movements to simultaneously steer the skis through the turn.
5. Control speed through turn shape.
6. Quiet stable upper body.

PSIA-RM –AASI www.psia-rm educational material; functional skiing exam criteria

Switch Riding:

1. Riding with the opposite foot in front. Board is riding backwards.
2. Ability to do this on green terrain.

TECHNICAL APPLICATION:

Equipment Set Up & Fit:

- Identify participant's profile diagnosis, ability, equipment, goals and motivations for lesson, etc.
- Participant should be comfortably setup in their designated equipment.
- Avoid putting pressure over medical devices and joints.

- Skier should be adjusted to allow for dynamic posturing.
- Equipment meets the needs of the students' goals and utilizes student abilities.

ATS: DRILLS AND PROGRESSIONS

- The American Teaching System (ATS). An all-encompassing teaching model that allows for other systems to coexist under and within it.
- Enables students to explore and to experiment with their own personal skiing or riding skills.
- ATS (American Teaching System) teaches to the whole participant and enables instructor to create a lesson plan based on the needs of the participant.
- Have basic knowledge of ATS progressions up to level 5.

MOVEMENT ANALYSIS:

- The instructor will have a basic understanding of the cause and effect nature of skiing/riding utilizing movement analysis matrix.
- Understanding the correlation between the ski performance and body performance throughout the phases of a turn.
- Observe participant performing the task.
- If there is a problem, specify where in the turn it occurs. Things that happen in one part of the turn affect the rest of the turn.
- Describe the participant's movement patterns in a positive way using quantitative, objective terminology (think D-duration, I-intensity, R-Rate, T-Timing).
- Most of the time we see the effect. Look for the cause.
- To create a different effect, develop a clear and consistent prescription for change that relates to the skiers goals. (A lesson plan).
- Begin to develop an understanding of the Movement Analysis Filter and how to create a lesson plan from Movement Analysis.

TETHERING:

- Properly attach tethers to participant or equipment (see Safety policy below)
- Instructor maintains dynamic positioning in relation to participant ('inside and above').
- Instructor stance should be in a dynamic position to allow for quick speed and direction changes while skiing behind the participant.

HOLDS:

- Depending on discipline, a basic understanding of manipulation and/or physical cues/assistance to help with dynamic positioning and provide a safe lesson.

EQUIPMENT:

- Instructors will be able to use, and be familiar with all adaptive equipment within the specific discipline that they are training in.

TEACHING AND LEARNING STYLES:

- Instructors should be able to use a variety of teaching techniques and styles; VAK (visual, audio and Kinesthetic/proprioceptive), Teaching Cycle and Learning Styles are examples.

SAFETY:

Client and Instructor Safety:

- The ability to 'see the big picture' and read the hill and your surroundings, keeping a safe distance between the instructor and participant as well as other people and/or obstacles on the hill.
- Refer to the Responsibility Code.

Emergency Stop:

- The ability to stop the participant and/or the equipment safely.
- Teach instructors how to use their hockey stop in relation to an emergency stop. Whether the instructor is tethering a participant or instructing an able-bodied participant.

Loading and Unloading:

- The instructor will show how to load and unload a chairlift, rope-tow, and magic carpet safely.
- The instructors will demonstrate how to use all safety straps, safety bar and retaining devices for their discipline.

Falling/Getting up:

- Know the proper techniques of how to fall and get back up within your discipline.
- Verbalize & demonstrate the proper way to teach your students how to "safely" fall.

| | |
|---|--|
| VOLUNTEER: (Print Name clearly) | INSTRUCTOR LEVEL: <input type="radio"/> LEAD <input type="radio"/> ASSIST <input type="radio"/> BUDDY |
| DATE: | TRAINER: <input type="radio"/> CURRENT <input type="radio"/> RECOMMEND <input type="radio"/> NO |
| DISCIPLINE: <input type="radio"/> BI <input type="radio"/> STAND <input type="radio"/> MONO <input type="radio"/> SNOWBOARD | PRIVILEGE: <input type="radio"/> BUCKET <input type="radio"/> BOOT <input type="radio"/> TETHER <input type="radio"/> SLIDER <input type="radio"/> GUIDE <input type="radio"/> RIDER |
| SITE (S): | WEIGHT LIMIT: |

| FUNCTIONAL SKI/RIDE | MEET | IMPROVE | COMMENTS | |
|------------------------------|------|---------|----------|--|
| Hockey Stop: L/R | | | | |
| Turning: L/R | | | | |
| Holding a Traverse/Side Slip | | | | |
| Backward Ski/ Switch Ride | | | | |
| TECHNICAL APPLICATION | MEET | IMPROVE | | |
| Equipment Set Up and Fit | | | | |
| ATS: Drills and Progression | | | | |
| Movement Analysis | | | | |
| Tethering | | | | |
| Holds | | | | |
| Equipment | | | | |
| Teaching and Learning | | | | |
| SAFETY | MEET | IMPROVE | | |
| Responsibility Code | | | | |
| Client/Instructor Safety | | | | |
| Emergency Stop | | | | |
| Chair Lift Load/Unload | | | | |
| Falling/Getting Up | | | | |
| Safety Policy Understanding | | | | |
| Communication | | | | |

I understand that I _____ (volunteer instructor) am trained to instruct only with the techniques, disciplines, and students indicated above, as evaluated by _____ the (volunteer trainer), and confirmed by the Program Coordinator.

Volunteer Signature _____

Trainer #1 PRINTED NAME _____

Program Coordinator _____

Trainer #2 PRINTED NAME: _____

COURAGE KENNY VOLUNTEER FEEDBACK FORM

Volunteer/Intern's Name: _____

Supervisor's Name: _____

Program: _____ **Date:** _____

Supervisor of Volunteers: Rate the volunteer based on what is appropriate to your particular program. Not all items will apply to all situations. This supervisory feedback form will be completed for all Courage volunteers/interns. A copy is kept in each volunteer/intern's file for future reference and for letters of recommendation.

Key: EXCEEDS = exceeds expectations; MET = met expectations;
IMPROV = needs improvement; NA = not applicable

| BEHAVIOR | EXCEEDS | MET | IMPROV | NA |
|---|---------|-----|--------|----|
| Professional characteristics: | | | | |
| 1. Punctual | | | | |
| 2. Reliable | | | | |
| 3. Flexible | | | | |
| 4. Attitude | | | | |
| 5. Assists participants achieve goals | | | | |
| 6. Respects confidentiality | | | | |
| 7. Understands & respects professional boundaries | | | | |
| 8. Accepts feedback/constructive input | | | | |
| 9. Modifies behavior with feedback | | | | |
| Interpersonal skills: | | | | |
| 10. Communicates with staff | | | | |
| 11. Communicates with program participants | | | | |
| 12. Cooperates with others | | | | |
| 13. Shares ideas/information | | | | |
| 14. Asks appropriate questions | | | | |
| 15. Able to problem solve | | | | |
| 16. Takes initiative when appropriate | | | | |
| 17. Seeks learning opportunities | | | | |

Please make a comment regarding the volunteer/intern's observed strengths and observed areas to develop.

STRENGTHS:

AREAS TO DEVELOP:

Supervisor's Signature

Date

Courage Kenny Ski & Snowboard Safety Procedures

Safety is a primary concern of Courage Kenny Rehabilitation Institute. Each instructor and any other contributor to the program is asked to follow and to help enforce the safety regulations, rules and policies adopted by Courage Kenny Ski and Snowboard Program. It is imperative that all instructors conform to current Courage Kenny Ski and Snowboard Safety procedures, in order to protect ourselves, our students, and our program for years to come.

Helmets

Helmets are required for all participants, volunteers, and instructors who are registered with Courage Kenny and skiing/riding on the hill.

Terrain Park/Pipe

- Going into Park and Pipe areas is permitted per the posted Park & Pipe Guidelines, with an instructor who has been approved by the Program Coordinator.
- Bi skis, Mono-skis and other pieces of sit down equipment are NOT permitted in the park area as it carries an unnecessary and inherent risk of damage to both persons and equipment.

Retention Belts

- Retention belts to be referred to as “Black Belts,” will be used on the chairlift for all students who have had a seizure within the last 5 years. If a student has been stable, with or without medication and without occurrence of a seizures for at least 5 years, a “black belt” is not required, but is still recommended.
- Retention belts are also recommended for students that are fidgety and are at risk of falling off the chairlift.

Bibs

Fluorescent bibs are required for Visually Impaired and Hard of Hearing/Deaf participants.

Fixed Outriggers

When using equipment with removable fixed outriggers, both fixed outriggers must be removed prior to loading the chairlift and remain off for the duration of the entire chairlift ride. This is to prevent a student from skiing unattached to a ski instructor without being able to arrest themselves while unloading the lift.

Retention/Safety Straps

- Retention straps will be used on all chairlifts for all equipment heavier than an outrigger. In any situation involving tethering, or assisting (seat assist or bucketing) with any participant unable, for any reason, to self-arrest (resulting from equipment design or ability), a tether must be affixed to the instructor with a self-tightening ‘girth hitch’ knot to the instructor’s skin on the wrist or elbow.
- The approved ways to tie into any piece of equipment is as follows;
 - Two single tethers both girth hitched to each wrist at the skin.

- A “horseshoe tether” with one wrist girth hitched to skin.
- A “horseshoe tether” with one wrist girth hitched to skin, and a harness or swami-belt with a daisy chain clipped to the main tether.

Incident Reports

Any incident to either volunteers, participants or instructors that requires medical assistance or first response should be reported to your site coordinator immediately. All incidents (even if no medical attention is needed) must be reported to your site coordinator. Your Site Coordinator will fill out the appropriate documentation and notify the Program Coordinator.

Emergency Response

In the event of an emergency:

1. Establish scene safety
2. Ask those involved if they are ok? Do NOT claim any responsibility for incident.
3. Call Ski Patrol
4. Keep the injured party comfortable without moving them.
5. Notify the Site Coordinator ASAP (as soon as possible).

If instructors have questions or concerns regarding safety, they should not hesitate to bring them to the attention of the Program Coordinator or Site Coordinator in an appropriate place and time.

Communication

- Good communication skills amongst the teaching team and participant.
- Communicate with parent/guardian on a weekly basis.
- If you can't attend your scheduled lesson call the Ski Hotline.
 - Metro Ski Hotline: 612-775-2282
 - Northland Ski Hotline: 218-726-4834 Ext 1

Responsibility Code: Know the 7 responsibilities codes of conduct

- Always stay in control, and be able to stop or avoid other people or objects.
- People ahead of you have the right of way. It is your responsibility to avoid them.
- You must not stop where you obstruct a trail, or are not visible from above.
- Whenever starting downhill or merging into a trail, look uphill and yield to others.
- Always use devices to help prevent runaway equipment.
- Observe all posted signs and warnings. Keep off closed trails and out of closed areas.
- Prior to using any lift, you must have the knowledge and ability to load, ride and unload safely.

Chair Lift Procedures

Before you get to the lift

- Review load & unload procedures. Practice as needed outside of the lift line.
- Remove any equipment that may impede your lifting abilities or safety (e.g., fixed riggers, or sometimes tethers)

- Know the lift sign language: **keep it moving** (finger moving in a circular motion); **slow down** (thumb down); **stop** (cut sign across the throat)
- Know and be able to explain the evacuation procedure
- Know your lift and be sure your co-instructor and guest know:
 - ✓ Can it be slowed at the bottom and/or the top?
 - ✓ Where do you wait in line?
 - ✓ Where do you position yourself to get on the lift?

If a problem occurs

- Don't panic
- Do not load or unload if you are not totally prepared
- Alert lift operator with any means possible (whistle, clap hands, yell, etc.)

Evacuation procedure

Ski Patrol has the ultimate responsibility for evacuation; offer suggestions as needed.

Loading procedure

1. Ask lift operator for a slow down if your student needs it (and if the lift can accommodate it).
2. Move to the load line and watch chair approach.
3. Count down and then sit or pull equipment up & back.
4. Make sure guest is seated as far back as possible.
5. Clip retention strap, if applicable. Co-instructor continues to hold on to guest or equipment.
6. Lower bar.

Unloading procedure

1. During the lift ride, review what will happen during unload. Remind co-instructor to hold onto guest or equipment while you unclip retention strap.
2. At appropriate distance (1-2 lift towers from top), unclip retention strap and hold it in your hand or clip it to the equipment.
3. Lift bar as you near the unloading load zone.
4. Count down and then stand up or lift equipment off the chair.
5. Assist student as necessary to make a straight run off the chair and then turn safely to a stop.
6. Adjust equipment as necessary so you may safely ski or snowboard

Courage Kenny Ski and Snowboard Program Best Practices

- The Power of Language
 - Putting the Person first
 - Communication

- Attitudes and Awareness
 - Think positive
 - Be Creative

- Disability Awareness

Power of Language

The words we choose to use have a huge impact on the outcome of any given experience. As adaptive ski and snowboard instructors it is your responsibility to be familiar with and use language that is current and that is positive by nature. To truly empower people to achieve their full potential we must keep in mind how we communicate and the words we use.

We ask that you keep it simple, and remember that no one likes to be referred to as an object (disabled skier) but better yet, a person that happens to have a disability. The use of the phrase “person first” reinforces the concept that we are first of all a person and secondly, a person with a disability. If we group all people together who have a disability (The Disabled Skiers) and contrast them with able-bodied (Normal Skiers) this creates a “them” and “us” image which ultimately creates a division. This directly opposes our philosophy of working toward creating a more integrated community where people of all abilities live, work & play together. It’s also very important to remember that all of us are only TAB’s (temporarily able bodied).

Using person first language demonstrates respect for your student!

Communication

Communication links us all together in every setting or activity. In teaching skiing and snowboarding, communication is the foundation for success. Imagine how frustrating it would be to attempt to learn to ski/snowboard if your instructor explained what they wanted you to do without demonstrating, checking for understanding or giving you examples, before moving onto the next step in the progression.

To ensure a mutually successful experience while volunteering in any of the Courage Kenny Ski and Snowboard Programs, clear & effective communication between all parties is

essential. Whether you're teaching a lesson, informing the Program Coordinator of a schedule conflict, or answering a question about the program while riding up the chair lift, clear communication is a must. By setting our communication standards high we ensure that the program runs efficiently. In practicing good communication, it allows us to be proactive, as opposed to simply reacting to issues regarding safety, scheduling or equipment, to name just a few examples. Please help us maintain the professional standards of teaching adaptive skiing and snowboarding that Courage Kenny Northland has delivered since 1979. Pledge your commitment to fantastic communication!

Communication is the foundation of all positive experiences!

Attitudes

The impact of your attitude as a volunteer in this adaptive ski and snowboard program is tremendous. Your attitude impacts the students, other volunteers, and ultimately the success of the program. Remember, you are creating unique skiing opportunities that would otherwise not exist for people with disabilities.

The general attitude toward people with disabilities is too often one of sorrow or sympathy and therefore, "we must help these special people." We ask that if you have this attitude, to throw it out the window and take a closer look at the big picture. In fostering such an attitude, we deny people their opportunity to fully express themselves and to discover their potential abilities, on or off the ski hill. Always do your best to look at what a person "can do" and not so much at what their limitations are.

Consider the attitude that people with disabilities simply might have a functional limitation requiring some specific modification to their ski equipment or style. Begin to develop a knack for identifying people's abilities and while encouraging them to 'go for it,' you'll also see a transformation in your student's own attitude toward themselves and what possibilities exist. Whether you're aware of it yet, you've already begun to adopt the attitude that we all deserve the opportunity to participate fully in the activities in our community & that our attitudes play a large role in making this a reality. "And so it is with you...we are in charge of our attitudes."

Attitude makes or breaks an experience!

Awareness

Awareness is an important factor in eliminating myths and stereotypes that unfortunately exist toward people with disabilities.

Awareness, as it applies to volunteering in an adaptive ski and snowboard program, is not only important to the participant's success, but to the entire program. For instance, we ask that you familiarize yourself with the various disabilities that people might have that participate in the program. While, at the same time, please keep in mind that their disability is just a small part of

their individual self. We also ask that you be aware of and utilize the numerous resources available to you as you work with the program. Just as you'll become aware of specific equipment & teaching techniques, you'll develop a more broad awareness of the individual skiers' abilities and desire to "Get Out There" & ski with everyone else.

Awareness is the key to success!

Helpful Hints & Suggestions

Keep in mind that the following list isn't complete, but it is designed to get you started on the right path toward becoming a well-informed adaptive ski and snowboard instructor.

1. Never assume....Always, ask first, discuss & then do
2. Don't do for others what they can do for themselves
3. Ask direct questions to participants. Don't talk around people i.e., Does he want to continue skiing?
4. If you don't understand an individual's speech, ask them to repeat themselves
5. Maintain eye contact and share the same eye level whenever possible, kneel or stoop when conversing with a person that's using a wheelchair or is shorter than you.

OUTLINE OF DISABILITIES

The information below is meant to be a general introduction to some of the disabilities that participants in CKSS Program. Some basic points should be mentioned before you work with an individual that may have a disability. To understand each participant and to enjoy your work you must remember that he/she is an individual first and the disability is second. A disability is not automatically accompanied with an intellectual disability. In general, treat children like children and adults like adults. By talking and showing interest to each participant, you will learn more about the person, his/her abilities and limitations, than you can get from a book or any printed information.

Many participants in Sports and Recreation Programs can often have more than one diagnosis. It is important to be aware of a secondary diagnosis and/or medical condition.

AUTISM SPECTRUM DISORDER

Autism Spectrum Disorder (ASD) is a group of complex disorders of brain development characterized in varying degrees. It is typically found in the early stages of brain development. ASD interferes with the normal development of the brain in the areas of reasoning, social interaction and communication skills. Children and adults with autism typically have deficiencies in verbal and non-verbal communication, social interactions, and leisure or play activities. The disorder can make it challenging for them to communicate with others and relate to the outside world. Because of this the person may have unusual responses to situations, people or attachments to objects and can also be very resistant to changes in routine. In some cases, aggressive and/or self-injurious behavior may be present.

Communicating with Children with ASD

- Slow down when speaking with your child
- Speak in short 2 or 3 word simple sentences (“come sit”)
- Stress key words with intonation
- Use gestures when speaking to enhance meaning
- Use visual supports - such as photos, pictures, items you are referring to, *pictures and schedules*.
- Be consistent—use similar directive phrases each session.
- *Keep motor progression demands to a minimum as many children with ASD are often uncoordinated and may have issues with balance.*
- *Do not stress skill mastery, stress participation, turn taking, and building soft social skills.*

Tips for Working with Kids with ASD

- Consistency, consistency, consistency: Keep the same routine with your participant each time, and do things the same way with other people. Without a consistent routine the child may become confused or upset.
- Whenever the opportunity presents itself, use a lot of positive reinforcement. Some children thrive on positive attention. Let them know when they are acting appropriately. Reinforcing good behavior decreases the need for kids to try to get negative attention.
- Remain neutral and calm, especially if a participant gets upset: Be sure not to raise your voice or show emotional reaction when your youth participant uses inappropriate behaviors. *Many children with Autism have sensory sensitivities. I'd recommend using a more gentle/quiet speaking voice, reduce lights or use natural light, keep noise at a minimum (radios, yelling, whistling, hand clapping) and do not touch them from behind. When touching someone with ASD, ask if it is ok to touch them and then use a firm touch not a soft one.* Redirect the child back to task or change the task.
- If possible, ignore any inappropriate behavior. Keep requests simple. Tell your child what to do rather than what not to do. Avoid using “stop” or “don’t” statements and always use a firm, calm respectful tone of voice. *Many children with ASD are slower auditory processors. Don't say a lot of words and give them more time to think about how to answer your questions. It is ok to repeat a question if you don't think the participant understood you. Many youth with ASD interpret language very literally so keep the slang to a minimum. If you say “hold your horse’s cowboy” the child may actually look for the horse and cowboy and not understand that you mean “slow down”.*
- Give the child two options rather than asking them what they want to do. For example, instead of “do you want to play?” Say “do you want to ride the red bike or the blue bike?”

As a ski instructor for someone with ASD: This Acronym may be helpful in lesson planning:

STARTS:

S Social/communication expectations

T Tips and Tricks from family or personal caregiver

A Any Medications or special dietary restrictions?

R Reinforcers

T Transitions

S Safety concerns

AMPUTATION

Amputation is the loss or removal of all or part of a limb or extremity such as an arm, leg, foot, hand toe, or finger. It can be congenital since birth or can be the result of an injury or disease, such as diabetes or cardiovascular disease. Typically, an amputation may impair an individual's mobility or impact the activities related to daily living, such as getting dressed, eating, or working. Many amputees use prostheses, or artificial limbs, to increase their independence.

ARTHROGYPOSIS

This disability is characterized by a continued state of flexion or contraction of a joint.

CEREBRAL PALSY

What is Cerebral Palsy?

Cerebral Palsy is a disorder caused by damage to parts of the brain which control and coordinate muscular action. Cerebral means brain and palsy refers to lack of muscle control.

What are some of the causes of CP?

- Premature birth
- Lack of oxygen to baby's brain
- Improper placenta placement
- Multiple births
- Disease of expectant mother (toxemia, German measles, etc.)
- RH incompatibility (It is not contagious or hereditary)

Can CP occur after birth?

Yes. Such things as lead poisoning, injury, certain illnesses and child abuse can cause CP to occur in a child who previously had no disability.

How can one tell if their child has CP?

Not all children are diagnosed at birth. The following symptoms are some clues that a child may have CP.

- Poor muscle control
- Poor coordination
- Muscle spasms
- Emotional problems
- Poor ability to concentrate

Are people with CP also Developmentally Cognitively Delayed?

No. A small a minority of people with Cerebral Palsy are Developmentally Cognitively Delayed but most are not. A speech difficulty does not mean developmentally delayed.

Are all people with CP the same?

No. There are different types of CP.

1. Spastic - The most common type, characterized by contracted, tense muscles and abnormal movement patterns.
2. Athetoid - Uncontrolled, involuntary movements (loose looking).
3. Rigid - Resistance to movement of muscles causing inelasticity of extremities.
4. Ataxic - Poor sense of balance, in coordination, often causing falls and stumbles.
5. Tremor - Uncontrollable shaking.
6. Mixed - Any combination of the above in the same individual.

A further classification indicates the location of the muscle involvement.

- Monoplegia: One extremity
- Hemiplegia: One side of the body (including arm and leg)
- Triplegia: Three extremities
- Quadriplegia: All four extremities
- Paraplegia: Both lower extremities

Can people with CP be cured?

There is no cure, but there are many ways to help people with CP lead fulfilled lives:

- Medications to control muscle spasms and seizures.
- Surgeries to help problems specific to an individual.
- Speech Therapy to aid people in better communication. (Those with severe speech problems may utilize talk boards, etc.)
- Occupational Therapy: Relearning fine motor coordination.
- Physical Therapy: Motor re-education
- Mechanical aids: Walkers, adaptive equipment.

- Personal counseling.

CLOSED HEAD INJURIES or Traumatic Brain Injury

A person who suffers an injury to the brain as a result of a traumatic impact (i.e. car accident) experiences disruption of all functioning abilities: (physical, intellectual, communicative, social and emotional). The recovery follows a fairly predictable course as described below. However, it is important to remember that every individual varies in how they experience a level and some may reach a plateau.

Automatic - Appropriate

The individual appears appropriate and oriented within hospital and home settings, goes through daily routine automatically, but frequently robot - like, with minimal to absent confusion, but has shallow recall of what he has been doing. He shows increased awareness of self, body, family, foods, people and interaction in the environment. He has superficial awareness of his condition, demonstrates decreased judgment and problem solving and lacks realistic planning for his future. He shows carryover for new learning, but at a decreased rate. He requires at least minimal supervision for learning and for safety purposes. He is independent in self - care activities. With structure he is able to initiate tasks as social or recreational activities in which he now has interest. His judgment remains impaired.

Purposeful and Appropriate

The individual is alert and oriented, is able to recall and integrate past and recent events and is aware of and responsive to his culture. He shows carryover for new learning if acceptable to him and his life role, and needs no supervision.

MULTIPLE SCLEROSIS

Multiple sclerosis is progressive neurological disease which affects nerve impulses that control walking, talking, seeing and other physical, sensory and behavior functions. MS affects each person differently - symptoms can range from mild - invisible - to severe. The need for assistive equipment such a wheelchairs, braces or communication devices will depend on the severity of the disease.

MUSCULAR DYSTROPHY - DUCHENNE TYPE

Muscular dystrophy is a progressive diffuse weakness of all muscle groups characterized by a degeneration of muscle cells and their replacement by fat and fibrous tissue. The cause is unknown. Boys are mainly affected and a clear inheritance pattern can be demonstrated in family pedigree.

In Duchenne muscular dystrophy the course is steadily downhill. Most children need to use wheelchairs by age 10 years. The usual cause of death in the later teens is from heart failure

(the heart muscle eventually becomes weak too) or overwhelming lung infection due to weakness of breathing muscles. As the children age, fatigue is more common.

OSTEOGENESIS IMPERFECTA

Osteogenesis Imperfecta translates into osteo (bone) genesis (beginning) imperfecta (imperfect) which means imperfect bones at birth, otherwise known as Brittle Bone Disease. Children with Brittle Bone Disease are born with numerous fractures and suffer repeated fractures in childhood which can result in skeletal deformities. Such as malfunctioning joint, stunted growth, barrel chest and often scoliosis. Children who have osteogenesis imperfecta have a history of being of above - average intelligence and swimming is one of the best exercises to control the wasting away of muscles and bones.

POLIO

What is polio?

It is a disease of the spinal cord and central nervous system. It is caused by a virus that can injure or kill certain nerve cells of the brain and spinal cord.

What are the effects of polio?

Muscles controlled by nerve cells that have been killed by the virus will be paralyzed. If the nerve cells are not too badly injured, they often recover and re-establish the pathway.

Post-polio syndrome (PPS) is the condition that affects many survivors of polio. Years after the initial attack the muscles will develop a new weakness and could potentially affect new muscles.

RHEUMATOID ARTHRITIS

This is one of the most common forms of arthritis; in fact, it is the most prevalent of all chronic diseases. The tissue changes that take place in rheumatoid arthritis proceed in a certain sequence. In the early stages, swelling of the joint or joints is the most characteristic feature. This swelling is due to active inflammation, particularly in the synovial membranes, capsule, and surrounding tissues. These inflammations, if not checked, lead finally to partial or complete obliteration of the joint cavity, with subsequent fibrous or bond ankylosis.

SPINA BIFIDA

What is Spina Bifida?

Spina Bifida or myelomeningocele is a defect in the spine that occurs early in the unborn child's development. It is caused by incomplete fusion of the spinal cord which leaves an opening in the spine. Through this opening, part of the spinal cord protrudes, forming a sac or cyst on the back which must be surgically removed.

How severe is this disability?

The extent and location of the defect determines the severity of the problem. Generally a myelomeningocele located in the neck or upper back area results in greater paralysis and disability than if it were located in the lower back. Myelomeningoceles in the lower back region causes varying degrees of paralysis of the legs and loss of bladder control. Some children and adults with this disorder require some type of bracing.

What problems are associated with Myelomeningocele?

Some of the most common are: Insensitivity of skin, paralysis and muscle weakness in the back and leg below the defect, lack of bowel and bladder control, hydrocephalus (accumulation of fluids in the head), scoliosis (curving of the spine), hip dislocations, feet and joint deformities and pressure sores. Many of these individuals have had a urinary diversion operation to alleviate the dysfunction of their urinary system.

- Children with spina bifida have minimal or no feeling in their lower legs and feet. Consequently they cannot feel their feet which can get cold or pressure points can develop in their boots.

SPINAL CORD INJURIES

What is spinal cord injury? (SCI)

Usually a catastrophic accident which damages the nerve cells at one vertebrae level can cause permanent paralysis resulting in paraplegia (both legs and lower part of the body) or quadriplegia (both legs and all or parts of arm movement and body movement - chest level down). In many cases the spinal cord is bruised - not severed. Motor damage is different with each person. The higher the injury the more paralysis occurs. The loss of sensation varies with each individual - from no feeling to partial sensitive feeling in paralyzed area.

What age group is prone to accidents causing SCI?

The young are prone to SCI. Two - thirds are under 35 years of age. About 78 out of 100 victims are males due to engaging in more dangerous sports and occupations.

What are the Causes of SCI?

Auto accidents are the leading cause. Other causes are motorcycles, sports, diving in shallow water, and industrial mishaps.

Do people who have spinal cord injuries get tired of sitting?

Yes? Wheelchairs are wonderful means to gain independence but constant sitting necessitates changing body position to prevent skin breakdown.

What are common medical problems people with a SCI have?

Skin breakdown.

Bowel & bladder control.

Difficulty with colds/infections.

SPECIAL CONSIDERATIONS FOR SKIERS WITH SPINAL CORD INJURIES

- A. Thermoregulation - Impairment may be seen in persons with spinal cord lesions above the navel and particularly at the cervical level, including some individuals with spina bifida (the clavicle bone upward). Adjustment to cooler ambient temperatures is low, inconsistent, or aided by the amount of cover over the person. Because of lack of sensation in lower extremities, the skier may not know if he/she is too cold.
- B. Spasticity - Hyperactivity of stretch reflexes. May be observed as increased resistance to quick, passive motion. It is manifested by involuntary contractions of the muscles below the level of the lesions. Seen in most individuals with high lumbar and above paraplegic and quadriplegic.
- C. Skin - Sores can easily develop in areas of sensitive skin caused by prolonged, unrelieved pressure over bony areas; e.g. butt bones, hip bones. All SCI persons have been taught the absolute necessity of avoiding prolonged pressure on the skin, lifting the buttocks every few minutes.

While skiing:

- 1. Beware of proper positioning in ski. Have person sit up straight in ski to avoid force on the sacrum portion of the vertebral column.

Look for areas of increased pressure/pinching.

The quadriplegic person may need assistance in repositioning every 30 to 45 minutes for pressure relief.

- D. Bowel/Bladder - Male paraplegics may have an external collection device consisting of a condom taped to the penis that is connected to a leg bag by a plastic tube.

Precautions:

- a. Leg bag should be emptied before skiing to prevent overflow, back up and subsequent blow out of catheter.
- b. If catheter loosens and leaks, bring person in.

Female paraplegics may have a continuous indwelling catheter inserted into the bladder which is connected to the leg bag with tubing. There is less chance of blowing out.

Others perform intermittent catheterization where a catheter is inserted into the bladder on a regular basis and removed every three to six hours. No collecting device is needed. Same precautions as above. Male and female quadriplegics usually have indwelling catheters. Same precautions as above.

Autonomic Dysreflexia - (Considered an Emergency Situation). This condition occurs in persons with spinal injury above T6 (just below the chest). It's a hypertensive crisis where the person experiences severe sweating, goose bumps, flushing, chilling without fever, severe pounding headache, high blood pressure, and increased spasticity.

Causes are bladder distention from a kinked catheter or overflow leg bag, preventing urine drainage out of bladder, catheter irritation, bowel distention, pressure sores or a stretch positioning of a part of the body; e.g. when hamstrings are positioned in an extreme stretch.

If conditions arise: 1) sit the skier upright; 2) unbuckle all straps 3) aid the person in checking the catheter for kinks or plugs; 4) decrease stretching of hamstring muscles, flex knees. Get person in immediately.

This is an emergency situation, and if not managed, could lead to stroke, coma and death. Fortunately, induced Autonomic Dysreflexia is a part of physical therapy and most will recognize the symptoms. Those with optimum bowel/bladder control will never develop this problem.

STROKE

What is a stroke?

A stroke is a cerebral vascular accident (CVA). It is an accident in which the blood supply to the brain is interrupted. It is the third leading cause of death in the U.S.

What are the causes of stroke?

1. The blocking of a blood vessel by a blood clot formed in the brain (thrombus).
2. The rupture of a blood vessel (hemorrhage).
3. The failure of cerebral blood flow due to a fall in blood pressure.
4. The pinching of a brain artery by a tumor or swelling (compression).
5. The movement of a blood clot in the circulatory system to the brain where it lodges in an artery (embolus).

Why do people have strokes?

There are many reasons, but some of the most common health conditions that increase the chances are:

1. Diabetes.
2. Infections that affect the heart and circulatory system.
3. High blood pressure (hypertension) can cause permanent narrowing of the arteries, making the heart beat faster. This is the most common cause of stroke.
4. Atherosclerosis - The buildup of fatty materials inside arteries.

All of the above conditions can be treated by a doctor before they become serious.

What are the effects of a stroke?

Depending on the severity, the following may be the physical results from a stroke:

1. Paralysis - typically on either the right or left side of the body (hemiplegia).
2. Memory loss and confusion (usually improves quickly).
3. Aphasia - difficulty with speech and language.

How does a person react emotionally to a stroke?

Mood swings can affect the person who has had a stroke. A person can experience anything from depression, to temper outbursts. It may be difficult for an individual to control their emotions at times, but this can change as recovery progresses.

What can be done for the stroke survivor?

Rehabilitation for the person can involve various approaches including counseling and speech and physical therapy. Each person is effected differently by a stroke. The survivor, their family, doctors and therapists all play a part in the success of the rehabilitation.

VISUALLY IMPAIRED

Impaired vision ranges from a very slight visual defect to total blindness in both eyes, and its causes are numerous. Many cases of defective vision can be corrected to the approximation of normal by properly made glasses.

Vision may be impaired or lost in one eye, but the degree of visual acuity in the other eye may be good. People who are partially sighted are those with serious defects who, with the aid of special devices, are able to read and perform tasks requiring vision; modern therapy is aimed toward preserving and developing the degree of usable vision such persons possess.

Blindness is the more familiar term for loss or absence of vision. Economic blindness refers to that state of vision which renders a person unable to do any kind of work for which sight is essential. Blindness, more specifically defined, means a central visual acuity of 6/60 (20/200) or worse with the best correcting lens, or a field defect in which the field has contracted to such an extent that its widest diameter subtends an angular distance no greater than 20 degrees.

ADD/ADHD

Attention Deficit Disorder, also referred to as Attention Deficit Hyperactivity Disorder is a term used mostly for those who are unable to concentrate on the task at hand. Many take the prescription drug, Ritalin. Individuals with ADHD are easily distracted and manage best when short-term goals have been determined. A reward system and realistic consequences may also be successful.

DEAF/HARD OF HEARING

An individual who is deaf or hard of hearing may need to use an alternative form of communication to interact with others. Some individuals may read lips, others may need to write on paper and yet others may need to use ASL (American Sign Language) an interpreter is an option for communication. Always try to communicate directly to the individual rather than to an interpreter or family member. If one means of communication does not work, try another or ask for help.

DIABETES

Involves an inability of the body to regulate sugar metabolism. This is often an inherited disorder. It is less common in children than among adults. In the child, it is difficult to control

and this is heightened by the fact that its importance is not always recognized by the child; consequently, he is likely to not adhere to his dietary restrictions.

Any signs of excessive perspiration, dizziness, agitation, headache, and unconsciousness should be reported immediately. Such signs might indicate either too much or too little insulin.

LEARNING DISABILITIES

There are several different types of learning disabilities. (L.D.) which may affect children with physical disabilities as well as able bodied children. These categories include dyslexia (difficulty with written or spoken language) dyscalcula (difficulty with numbers) and Attention Deficit Hyperactive Disorder (attention problems). An increasing number of children in the developmental stages of life suffer from L. D. Some symptoms to be aware of are short attention span, easily distracted, hyperactivity, impulsive, trouble understanding words or concepts, and may adjust poorly to change. Using a variety of teaching/instruction techniques may help to keep the individual interested and focused on an activity.

TOURETTE SYNDROME

Tourette syndrome is a physical disorder of the brain which causes involuntary movements (motor tics) and involuntary vocalizations (vocal tics). Motor tics can occur in any part of the body, and include eye blinking, facial grimacing, shoulder shrugging, head jerking, and hand movements. Common vocal tics include throat clearing, sniffing, making loud sounds, grunting, or saying words. Both motor and vocal tics may occur many times a minute, or only a few times a day.

SEIZURES

Individuals could experience epileptic seizures at any stage of life. However those who have a history of seizures take medication to control them. Seizure activity can vary from an all out episode of convulsions and falling to the ground (Grand Mal seizure) to a slight stare or blank look (Petit Mal) and lots of variations in-between.

FIRST AID FOR SEIZURES

The Grand Mal Seizure

During the seizure:

The person may fall, stiffen and make jerking movements. Pale or bluish complexion may result from difficult breathing.

Help the person into a lying position and put something soft under the head.

Remove glasses and loosen any tight clothing.

Clear the area of hard or sharp objects.

Do not try to restrain the person, you cannot stop the seizure.

Do not force anything into the person's mouth.

After the seizure:

The person will awaken confused and disoriented.
Turn the person to one side to allow saliva to drain from the mouth.
Do not offer the person any food or drink until fully awake.
Arrange for someone to stay nearby until the person is fully awake.

Reasons for a 911 Call

The person does not start breathing after the seizure. Immediately call 911 and begin CPR and first aid.

The person has one seizure right after another.

The person was injured during the seizure.

The person requests an ambulance.

Myoclonic Seizure (Petit Mal)

Usually a myoclonic seizure isn't as long or severe as a Grand Mal seizure. A myoclonic seizure may involve contractions of a portion of a muscle, an entire muscle, or a group of muscles. A person may be able to continue with activity while the petit mal seizure is occurring.

Best Practice - Volunteer/Participant Guidelines

Client Interaction Guidelines

All staff members and volunteers must follow these guidelines when interacting with participants.

1. The relationship with a participant must remain a working and professional relationship at all times.
2. HIPPA (Federal Health Insurance Portability and Accountability Act) the protection of confidentiality and security of healthcare information and all personal information.
3. Keep any of your own personal information to a minimum. Do not give your telephone number or address to a participant. Do not call a participant or write to them at their home.
4. Always inform a staff member if a participant tells you about a personal need, problem or concern that is worrisome.
5. Never promise a participant that you will keep his or her secret.
6. Leave the room door open when working with a participant.

Examples:

- Do not return any sexual advances a participant may offer you. Be firm about your refusal. A flirting response may encourage this behavior to continue
- Do not intimately touch a participant. This includes excessively patting a shoulder, touching a hand, leg or other body parts, etc.
- Do not hug or kiss a participant, even as a sign of praise.
- Do not share inappropriate personal information about yourself with a participant.
- Do not accept invitations to dinner, outings, parties, etc., when outside the scope of your work.
- Do not accept any personal gifts or gratuities from a participant unless they are of minor value or of common practice. Any such gift must be reported to your site coordinator.
- Do not borrow money from or lend money to a participant.
- Please do NOT use sarcasm as a means for communication it is often mistaken by people.
- Do not take everything a participant says at face value. Because of some disabilities, a participant's perception and/or information may be inaccurate. Always clarify the information before taking any action.

***If you see or suspect any kind of violation of best practice
talk to your site coordinator immediately!***

1. As with any difficult individual try to find a solution to the problem.
2. Let the person know that the behavior is not appropriate and that you will not tolerate it, especially if it invades your privacy or if you feel threatened.
3. Do not blame the person; react only to the behavior. Focus on resolving the problem.
4. Do not raise your voice and don't condescend when speaking with your participant.
5. Don't use sarcasm or argue.
6. Participant's behavior is aggressive, either verbally or physically, take the situation seriously. Try to reduce the stress of the situation. If that doesn't work, call your site coordinator. If the behavior is physically threatening, contact your supervisor and security immediately.

BRIEF RESOURCE LIST

To receive more information on adaptive downhill skiing and snowboarding techniques.

Books/Manuals

Bold Tracks, Hal O'Leary, Founder of National Sports Center for the Disabled in Winter Park, Colorado (970-726-1540)

PSIA Adaptive Snowsports Instruction Manual can be purchased through the PSIA website – www.psia.org

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