



# Outdoors for All Foundation

## Winter Volunteer Manual

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## **Welcome to Outdoors for All**

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Thank you for choosing to volunteer with the Outdoors for All Foundation. In 1979, Outdoors for All was incorporated as a 501(c) (3) nonprofit organization called the Ski for All Foundation. Today, we're the Outdoors for All Foundation: pursuing our mission to enrich the quality of life for children and adults with disabilities through outdoor recreation. We look forward to your help in achieving that mission.

### **This Manual**

This manual is designed for you, our Outdoors for All volunteer. It presents a great deal of information, with the purpose of familiarizing you with Outdoors for All and ensuring that your volunteer experience is safe, enjoyable, and enriching.

### **Who We Are**

Outdoors for All began in 1979 through the passion of volunteers and ski school staff who saw the need to start an adaptive ski program at the Summit of Snoqualmie – teaching 35 participants with developmental disabilities to downhill ski.

Over the last three decades, Outdoors for All has grown to include year-round outdoor recreation programs, serving more than 2,400 children and adults with disabilities each year – all thanks to the support of *more than 700 volunteers*. In 2006, we changed our name from the Ski for All Foundation to the Outdoors for All Foundation, in honor of our commitment to year-round, outdoor adaptive recreation opportunities for children and adults with disabilities.

The winter program at Outdoors for All has grown to include alpine skiing and snowboarding, sit-skiing (mono-ski and bi-ski), snowshoeing and cross-country skiing. Our winter programs operate at two different mountain sites, The Summit at Snoqualmie and Stevens Pass. Off-snow programs throughout the year include day camps, cycling, mountain biking, hiking, kayaking, rock climbing and camping excursions. These programs take place at a variety of trails, parks, lakes, and rivers around Washington State and the Pacific Northwest.

Outdoors for All programs are funded through a variety of sources, including government grants, private donations (from foundations, corporations, and individuals), and participant fees. Participant fees account for only 35% of our annual budget, while the remaining 65% of the cost of running our activities is covered by donations and grants.

Outdoors for All is committed to providing recreational opportunities to any individual who needs financial assistance in order to access our programs. We award more than \$65,000 in financial grants to individuals and community programs each year, which makes access Outdoors for All's adaptive recreation programs more affordable.

### **Adaptive Recreation Programs**

Outdoors for All is a leading expert in adaptive outdoor recreation in the Pacific Northwest. Our fleet of adaptive equipment is the largest in the area, and it includes specialized equipment for each of the programs that we offer. Our services are primarily focused within Washington State; however, we do provide services in neighboring states upon request.

Nationwide, Outdoors for All is one of the largest nonprofit organizations providing year round instruction in outdoor recreation. Our programs are designed to serve individuals, ages five and up, with all types of disabilities, including physical, cognitive, developmental, and sensory impairments.

Please review our website [www.outdoorsforall.org](http://www.outdoorsforall.org) for more information about our programs!

## **Volunteer Roles**

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Depending on their specific volunteer role, volunteers may report directly to the Lead Volunteer or the Program Managers for each program. Winter volunteer roles include (but are not limited to): Instructor, Race Coach, Race Crew, Driver, Vehicle Chaperone, Equipment Manager, Lodge Assistant, Lead Volunteer, and Clinician. For a complete listing of our winter volunteer roles, please review the Outdoors for All website.

## **Volunteer Responsibilities**

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Regardless of your volunteer role, your primary responsibility as an Outdoors for All volunteer is to provide support to Outdoors for All participants. This includes creating a safe, fun, and positive learning experience for both yourself and the participant. Our priorities are safety first, fun second, learning third.

## **Winter Volunteer Commitment**

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### **Lessons and Absences**

Lessons are held at The Summit at Snoqualmie (Summit West) or The Summit Nordic Center, and Stevens Pass. Please refer to the Outdoors for All website for more information about each program.

Instructors who commit to teaching a full 7-Week Lesson Series in January/February, and who also choose to purchase a discounted season pass through their respective mountain location, are *required* to make up any absences during another program day at the same mountain they volunteer at. To sign up for make-up days, please sign up on our website under Upcoming Volunteer Opportunities [here](#).

If you are unable to attend a program session last-minute, please call and leave a message on the Outdoors for All Hotline at (206) 838-4995.

### **Cancellations**

Outdoors for All occasionally cancels lessons due to bad weather or road closures. If this happens, make-up lessons will occur during the week(s) immediately following the regularly scheduled program.

Before driving to your program location, please call the Outdoors for All Hotline at (206) 838-4995 to check for any changes to the daily schedule.

Outdoors for All does not offer make-up lessons for participant or volunteer absences. Our participants depend on you to follow-through on your volunteer commitment.

### **Training Commitment**

All first-year winter volunteers must complete 4 full days of training (9am-3pm)

All new volunteers must also attend an Outdoors for All Orientation prior to volunteering

2<sup>nd</sup> year volunteers must complete 2 full days of training (9am-3pm)

3 + year volunteers must complete 1 full day of training (9am-3pm)

Every volunteer must complete the online training and receive a 100% score (you may take the test as many times as needed) prior to receiving their pass or teaching a lesson

Any and all training exceptions should be approved by the Program Director  
All excused trainings must be made up. Contact the volunteer coordinator to schedule your training make up day

There will also be opportunity for you to attend extracurricular trainings (on top of the required pre-season training) on Wednesday evenings from 7-9pm. You can see what's offered and sign up through our website.

## **Day in the Life of an Outdoors for All Instructor**

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- Instructors should arrive about 45 minutes prior to the start of lessons, and should plan on staying for 30 to 45 minutes after lessons to put away equipment and complete paperwork.
- When you arrive, check-in with your Lead Volunteer or Program Manager.
- Get yourself and your gear ready for the day.
- Attend the Instructor Meeting, sometimes called the "Morning Meeting" for day-time programs.
- Review your participant matching for the day, as this may change from week to week. Review your participant's Progress Report from previous weeks, and begin to make a plan for the day.
- Pull and prep any rental gear for your participant, and get his/her lift ticket, if needed.
- Greet your participant and discuss his/her goals for the day. Gear-up, and head out on the hill. Take breaks as needed.
- Break for lunch or dinner. If you are matched with a full-day participant, please stay with them unless you have arranged alternate supervision. This can be a great opportunity to learn more about your participant and gain a deeper rapport.
- Enjoy afternoon activities on the snow, with breaks as needed.
- Return your participant's equipment and complete their Progress Report. Support participant independence, and engage them in this process! Summarize the day, note any highlights or accomplishments, set goals for next week and discuss any changes to their schedule.
- Ensure that your participant connects with their ride home, and has all of their belongings. If your lesson is running late, please connect with your Lead Volunteer to ensure that your participant does not miss scheduled transportation.
- Check-in with your Lead Volunteer or Program Manager, before leaving for the day.

## **Goal Setting**

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Goal setting is an important aspect of programming in order to ensure that the participant is meeting his or her wants and needs. Before lessons or programming begins, have a conversation with the participant and/or his caregiver to discuss desires and expectations. It is important to note that goals might not always be directly related to the activity (skiing, snowboarding, etc.), and instead, may be social, emotional or physical in nature.

If possible, create SMART objectives. SMART objectives are Specific, Measurable, Attainable, Relevant, and Time-Bound. The more specific the objective is, the easier it is to hold each other accountable.

### **Examples of SMART objectives:**

By the end of the series, \_\_\_ will attempt 3 "blue" runs.

By the third week, \_\_\_ will engage in appropriate conversation with two volunteers and one participant.

\_\_\_ will demonstrate parallel turning by the end of the series.

**Examples of 'poor' objectives:**

\_\_\_ will get better at skiing.

\_\_\_ will have fun.

## **Progress Reports**

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Progress Reports are an important part of every Outdoors for All lesson. Progress Reports help staff, volunteers and participants track on goal-setting, skier/rider improvement and participant behavior. Progress Reports are also an important way for Instructors to communicate tips/tricks and lesson plans, for a student who may have more than one instructor over the course of a lesson series. Please remember to complete a Progress Report at the end of every lesson!

## **Risk Management**

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There are certain risks and dangers inherent in any activity, and the field of adaptive snow sports involve its own specialized set of risks. The goal of the following safety policies, guidelines and procedures is to identify the risks that we face and to develop methods by which these risks may be reasonably controlled to provide a safe and fun learning environment.

The following material provides an overview of the major points of risk management within Outdoors for All's winter programs. This is not an exhaustive list; rather, this offers a baseline from which each individual volunteer should operate.

## **Volunteer Guidelines**

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- Absolutely no use of **alcohol, marijuana or illegal drugs** before or while you are volunteering for Outdoors for All. This includes during lunch, if you are teaching a full-day lesson. Violation of this policy will lead to termination of your position and/or other disciplinary action.
- **No smoking** during Outdoors for All programs, or in Outdoors for All buildings or facilities.
- **Be prepared!** Keep your body in shape, get plenty of sleep, take precautions when driving to the mountain, keep your equipment safe, stay warm, and eat to keep your energy up.
- **Have knowledge of all terrain** and select terrain appropriate for your student.
- **Be knowledgeable of snow conditions** and how they affect skiing. Plan your lesson accordingly.
- **Act professionally** at all times while representing Outdoors for All.
- In the case of an **unexpected absence**, call your Lead Volunteer or staff member and/or the Outdoors for All Hotline as soon as possible! If you miss one lesson without notification, or if you are consistently late for instructor meetings or lessons, you may **lose your season pass privileges**. If you have a scheduling conflict, talk to your Lead Volunteer as soon as possible.
- **Outdoors for All does not arrange carpools.** Volunteers assume full responsibility for transportation to and from events, unless they are traveling in one of the Outdoors for All vehicles. We recommend that you set up a carpool group with other volunteers in your program.
- Outdoors for All staff and Lead Volunteers are **not responsible for any personal items** left in any of the Outdoors for All buildings or facilities. Do not store any personal equipment overnight in any of the Outdoors for All buildings or facilities.
- Staying overnight in the Outdoors for All buildings/facilities is prohibited.



- **Outdoors for All does not provide medical insurance or workers compensation for our volunteers.**

## **Participant Guidelines**

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- Before working with any participant, **review his or her Participant Information Form (PIF) and past Progress Reports.** If you notice anything that concerns you, please notify your Lead Volunteer, or program Manager immediately. Please be respectful of the information on a person's PIF and do not discuss any 'issues' with other participants or volunteers.
- Ensure that participants are dressed and protected from existing weather conditions. Never take participants into adverse weather with inadequate clothing or equipment.
- During the lesson, check participants for cold or numbness in the extremities, signs of heat loss, and his/her comfort level. If you are concerned, bring the participant indoors.
- **Do not administer any medication, prescription or non-prescription, to any participant.**
- Due to various participant dietary restrictions and food allergies, **do not provide food or meals to a participant,** unless it is food that they have brought with them. If a student forgets his or her lunch or lunch-money, please notify your Lead Volunteer.
- Ask permission from your participant before touching them. Although many activities necessarily include physical contact (such as transfers), you should still ask for permission.
- If a participant informs you that he or she is being mistreated or harassed during any Outdoors for All activity, report the incident to your Lead Volunteer or Program Manager.

## **Confidentiality**

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In the course of your volunteer activities with Outdoors for All, you may have access to participant information, including medical information, as well as other proprietary information and data. You are expected to not disclose this information outside of Outdoors for All at any time during, or subsequent to, your volunteer activities. Unauthorized use or disclosure of participant information may subject you to civil liability under Washington State law.

## **Equipment Guidelines**

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Outdoors for All uses a wide variety of equipment during Winter Programs. To keep our equipment organized and in good working condition, please remember to:

- **Check all equipment** before, during and after your lesson. Any deficiency that affects the operational safety of the participant's equipment must be reported to your Lead Volunteer, Equipment Manager or Program Manager, and the equipment should be taken out of service. Fill out an equipment repair tag and attach it to the piece of equipment
- **Clean all equipment** of snow, ice, dirt and water before and after use.
- Return all equipment to its proper place after use.

## **Alpine Ski Binding Adjustment**

Ski binding adjustment is an important aspect of Outdoors for All's risk management. **Instructors may not make any adjustments to a participant's ski bindings.** If your participant is having issues with his or her Outdoors for All rental equipment, please see the Equipment Manager or Program Manager for

assistance. **All Equipment Managers and Program Managers working with Outdoors for All's rental ski bindings must be Marker Binding Certified for the current season.**

If your participant is having issues with his or her personal equipment, or with equipment rented from another organization, please refer him or her to a ski shop. **Outdoors for All staff and volunteers, regardless of his or her training, may not make adjustment to a participant's personal ski equipment, or equipment that is rented from another organization.**

### **Retention Harness**

Any participant who has experienced a tonic-clonic seizure (formerly grand mal) within the last 24 months is **required** to wear a retention harness while riding the chairlift. It is recommended that a participant who has experienced any other kind of seizure within the last 24 months wear a retention harness on the chairlift.

If your participant does have a seizure while on the chairlift:

- Remain calm, and ensure your own personal safety before attempting to assist the person having a seizure.
- Do not attempt to hold the person.
- Notify the lift attendant before reaching the top that you will require a full stop to unload. Do not unhook the retention strap from the chair until you have come to a full stop at the top of the chairlift.
- Ask the lift attendant to notify Ski Patrol.
- Once Ski Patrol has taken control of the student's well-being, notify your Lead Volunteer and an Outdoors for All staff member.

### **Helmets**

Outdoors for All's helmet policy requires **participants, volunteers, and any participating family and caregivers** to wear helmets when actively participating in Downhill Skiing, Downhill Snowboarding, and any other activity when directed by Outdoors for all staff and released parties. The selection and use of an appropriate helmet is the sole responsibility of the user. Outdoors for All will not be liable for any injury or damages resulting from failure to use a helmet or incorrect use or selection of a helmet.

**WARNING:** Outdoor activities are inherently dangerous and use of a helmet is no guarantee of safety and the activities requiring the use of a helmet may expose the participant to forces that exceed the limits of protection provided by a helmet.

### **High Visibility Vests**

Participants with visual impairments and their guides must wear VI bibs.

### **Equipment Tethers**

When tethering any sit or stand equipment from behind (Alpine or Nordic), the tether line must be attached with a girth hitch to the instructor's skin at the wrist. This is also true if you are tethering a stand up skier. This is to prevent the tether line from coming loose if the instructor loses his or her grip on the tether line, or if the instructor were to fall. The tether line must be attached to the equipment with a

locking carabiner or a girth hitch. If applicable, the tether line must be attached to the manufacturer's recommended attachment point.

When tethering a stand-up skier, acceptable points of attachment between the tether and student are the tips of the skier's skis or a waist harness. Never attach tethers to a skier's boots.

All tethers must be approved Outdoors for All tethers.

Outdoors for All strongly encourages the use of two separate tethers (as opposed to one long tether line) when tethering a bi-ski. New bi-ski instructors should expect to practice tethering with two individual tethers.

## Sit Skis

When teaching a mono ski lessons, always use a heel piece binding block to prevent the bucket from ejected out of the bindings.

Prior to using any sit-ski equipment, ensure that the evacuation system is ready and accessible. This includes having a locking carabineer available for use in the event of a chairlift evacuation. This is only true for alpine sit ski equipment as the Nordic sit ski is not allowed on the chairlift under any circumstances.

**In any situation where a student in a piece of equipment cannot self-arrest, then the equipment should be tethered via two points of contact to the instructor at all time. All sit-skis with fixed outriggers must always be tethered by the instructor.** There are no exceptions to this rule.

**All fixed outriggers must come off the bi-ski before loading a chair lift. Fixed outriggers should also be removed if you are doing a full run with a bucket assist.** This is for the safety of the instructors and the student.

Tethering prevents runaway equipment. If any instructor does not feel comfortable being fixed to the tether line, make alternate arrangements. The safety of the instructor is as important as the safety of the student

1. An approved sit ski tetherer (Primary Sit Instructor) must be the primary instructor on every sit ski lesson. He or she must be approved by a Lead Sit Clinician.
2. An instructor may not tether for the first time in a lesson setting. His or her first experience on tether must be in a clinic or training setting.
3. It is up to the discretion of the Primary Sit Instructor assigned to the lesson if another instructor (with some previous training experience) may tether during that lesson.

## Chairlift Loading and Unloading Procedures

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### General Loading Guidelines

- Lift line policy
- Always explain the loading procedure to the student before loading a chairlift for the first time. Use common sense and focus on safety. Allow the student to be as independent as is safely possible.
- Make sure to perform a dry run with the lifting assistant when loading sit equipment
- Make sure that the sit equipment is in load position
- When using a Mountain Man bi-ski remove the load miller pin prior to loading and put it back prior to skiing
- Make sure the retention strap is readily available.
- Any tethers used for sit or stand students must be removed from the instructor's wrist(s) prior to reaching the loading area.
- The instructor and the lifting assistant must communicate with the lift operator, as well as with each other. Typically, the person with the best view of the chair counts out loud for the load.
- Use proper lifting techniques. Lift with your legs, not your back.
- If the student is too heavy for you to lift, get help or switch students. Do not attempt to lift loads that are too heavy for you.
- All students with hand-held outriggers (stand **and** sit) should **unload** with the outriggers in the skiing position—this is to prevent any potential shoulder injuries during the unload.
- **All sit skis with fixed outriggers must be removed from the ski before loading the chair lift.**
- Students skiing with a snow slider should use the slider to get to the loading ramp. The student may ride the chairlift with the slider resting across his or her lap, or the slider may be passed off to an assistant instructor who will carry it up the chairlift on a different chair. **Once on the chairlift, the slider must be tethered to the chair.** Please see your Lead Volunteer or Program Manager if you have any questions.
- **If the chairlift that you're riding has a "safety" bar, you must lower the bar while you're riding the chair.** This guideline applies to all students and instructors, regardless of any equipment or adaptations in use. If you're unsure how to lower the bar while using a specific piece of equipment (such as a sit-ski or the slider), please see your Lead Volunteer or Program Manager.

## Loading Speeds

- Each chair loads at a different speed. The instructor is responsible for determining which speed is best for each load/unload.
- Prior to entering the loading ramp, notify the lift attendant of your desired speed for the load and unload, as well as any special instructions. For example: "I would like a slow at the bottom, and a full-stop up top. Can I please have a pull back?" **PLEASE NOTE:** If you ask for a "pull back", make sure there is a second lift attendant available to stand near the "stop" button in the event of a mis-load. It is not recommended that you ask for or receive a "pull back" if there is only one lift attendant at the bottom of the chairlift.
- It is the instructor's responsibility to make certain that the lift attendant knows the desired speed for the load and unload before entering the loading area. **Never assume** that the lift operator knows what you want, or that he or she will remember what speed you took for your last run. Be clear and always communicate.
- It is acceptable to let empty chairs pass if either the instructor or student is not ready to load.
- If a mis-load is inevitable, signal to stop the chair immediately to avoid making the situation worse.

## Retention Straps

All students using a sit-ski, as well as all students wearing a retention harness, must be secured to the chair by a retention strap. The retention strap should be wrapped around a primary structural component of the chair, and the carabiner is then attached back onto the safety strap itself. Please note:

- The thin metal slats on the backs of chairs are not part of the chair's primary structure. Therefore, the retention strap should not be attached to these slats.
- Do not use a locking carabiner to attach the safety strap around the chair. Locking carabiners may freeze when locked, preventing an unload.
- When loading, make certain that the student is as far back on the chair as possible. **Attach the participant's retention strap to the chair as soon as possible, and ask for a STOP if attaching the strap becomes an issue.**
- Do not hesitate to stop the chair if you can't attach the retention strap. SAFETY FIRST!

## Unloading Guidelines

- Explain the unloading procedure to the student prior to unloading. You should also make the participant aware of when they are and are not attached to the chair. Unloading takes practice.
- If the safety of the unload is in jeopardy, remain on the lift and notify the lift operator to stop the chair. Never jump from the chair lift.
- As you approach the top of the lift, make visual contact with the lift operator and indicate your desired speed for the unload (stop, slow, full speed) using hand signals. The lift operators at the top have been instructed to follow your hand signal.
- The timing for when you should detach the carabiner, unwrap the retention strap and raise the chairlift bar depends on each specific chairlift. Please check with your Lead Volunteer regarding the lifts that you will be using during your lesson.
- Instructors should remain on the chairlift until the sit-skier is safely off the chairlift

## Hand Signals

- Full Speed: Thumb up.
- Slow/Half Speed: Thumb down.
- Full Stop: Arm extended, palm facing the lift operator.

## Chairlift Evacuation Procedures

- Stay calm, and stay in the chair. Never attempt to remove yourself or your participant from chair.
- Talk to your participant and keep them calm.
- Wait for Ski Patrol. Ski Patrol will walk you through the evacuation procedure step by step.
- If your participant uses a retention strap, keep the strap secured until they are securely connected to the evacuation line.
- Never drop anything (skis, handheld outrigger, etc.) from the chairlift.

## **Terrain Parks**

Instructors should only take participants on features in the terrain park if the student can ski them independently. Equipment should only go over features if it is designed to be able to do so safely

## Responsibility Code

It is important to integrate the seven points of the Responsibility Code into each of your on-snow activities. Be a role model for safety, and remind your participant and fellow volunteers of safety concerns on a regular basis.

### Responsibility Code

- 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 knowledge and ability to load, ride, and unload safely.

**KNOW THE CODE. IT'S YOUR RESPONSIBILITY.**

This is a partial list. Be safety conscious.  
Officially endorsed by: NATIONAL SKI AREAS ASSOCIATION

## Incident Procedure Guidelines

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Any incident related to Outdoors for All must be reported to a Lead Volunteer and a Program Manager in a quick, accurate, and responsible manner. Please adhere to the following guidelines if you witness or experience an incident while volunteering for Outdoors for All.

### 1. Get Help

**Send one or more competent persons (preferably an adult) to get Ski Patrol.** Have them note the exact location of the injured person so that they know where to send Ski Patrol. If you feel the need to send a second messenger, make sure the person tells the Lift Operator they are a "second runner" so as to avoid confusion. Make sure you have Ski Patrols phone number saved into your phone prior to going out on a lesson.

### 2. Protect the Accident Site

**Cross your skis above the accident scene to clearly mark your location.** Ask a bystander to assist you by hiking uphill a short distance to direct traffic away from the accident.

### 3. Protect the Injured Skier/Rider

**Do not move the injured person except when it is necessary to protect them.** In a life-threatening situation, apply immediate first aid to the best of your capability. Stop severe bleeding by direct pressure. If you are trained in CPR, begin artificial respiration if the injured person is not breathing. Treat for shock by keeping the injured skier warm, comfortable, and lying down until Ski Patrol arrives. Avoid any contact with body fluids (such as saliva and blood) without protection. **Never administer food, drink, or**

**medications.** Stay calm. Talk to the injured person; tell them what is happening. Obtain witness' names, addresses and phone numbers.

#### **4. Do Not Discuss the Incident**

**Do not discuss the incident with anyone other than your, Outdoors for All staff members and Ski Patrol.** Do not give an opinion, place blame, or admit guilt – just state the facts. Legal liability for an incident is never determined on the scene. If it becomes an issue, all relevant facts and circumstances are investigated and analyzed. Statements such as "I shouldn't have ..." or "I'm sorry ..." are usually interpreted as admission of legal liability that obscures other relevant facts.

Go with the injured skier to the Ski Patrol building. If you have more than one student, go only after handing the other student off to another Outdoors for All Instructor, Lead Volunteer or Program Manager. Provide Ski Patrol with the individual's Participant Information Form, if applicable, so that they are aware of any important medical considerations.

#### **5. Fill Out an Incident Report Form**

**Fill out an Incident Report Form with your Lead Volunteer or an Outdoors for All staff member.**

Please review the blank Incident Report Form at the end of this section. No matter how small the incident may be, it's important for your Lead Volunteer and the staff know about it. When filling out an Incident Report Form:

- Use legible writing.
- Use complete sentences.
- Be objective.
- Get the names and witness statements from all those who saw the incident.
- Complete the form as soon as possible after the incident, preferably within 24 hours.
- Do not leave any blank lines. Do not abbreviate. Instead of "N/A", write "does not apply".

**REMEMBER**, the Incident Report Form may be the only thing you have to refer to five years after the incident. Make it accurate, succinct, and complete.

#### **6. Follow-Up**

An Outdoors for All staff member will follow up with the person once they've been treated. **Follow up with your Lead Volunteer and/or the Outdoors for All staff member to check on the status of your participant after their injury.**

#### **Lost child policy**

Prior to heading out on the slopes it is best to name a meeting place where you will go if you become separated.

If you do lose your student, notify your Lead Volunteer and Outdoors for All manager so they can start the emergency action plan and help you find your student. Notify Ski Patrol and the lift attendants so they can help you find the student. Note what the student was wearing. Split up with your co-instructor to start looking for your participant on the trails and lifts you were recently on.



**PLEASE REMEMBER:** When in doubt, seek advice from your Lead Volunteer or Program Manager.  
If you have any questions concerning any of the above policies, please contact the Outdoors for All office.

## Incident Report Form

### INCIDENT REPORT FORM

Use back if more space is needed.

(Be complete – write legibly – no blank lines – do not abbreviate.)

Activity	Date: _____ Time: _____ Activity: _____ General Location: _____
Injured Party	Name: _____ <input type="checkbox"/> Participant (Address on file with Outdoors for All.) <input type="checkbox"/> Volunteer
Location Description	Exact Location: _____ Description of Area (Be Detailed): _____ _____
Injury	What was the person doing when injury occurred? _____ _____ _____ Description of Injury: _____ _____ Injured party's description of incident ("exact words"): _____ _____
First Aid	1 <sup>st</sup> Responder Name: _____ First Aid: _____ 2 <sup>nd</sup> Responder Name: _____ First Aid: _____ Professional medical service rendered? <input type="checkbox"/> Yes <input type="checkbox"/> No Did injured party return to activity? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____ _____
Witnesses	Name: _____ Phone: _____ Address: _____ Name: _____ Phone: _____ Address: _____ Name: _____ Phone: _____ Address: _____
Volunteer Information	Volunteer Name: _____ Phone: _____ Signature: _____  Supervisor's Name: _____ Phone: _____ Signature: _____
Follow-Up (Completed by Staff) Incident # _____ Date _____ Staff Name _____ Title _____ Spoke to whom (name and relationship): _____	

What was said: _____ _____ _____
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## **Disability Awareness**

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Every person, regardless of gender, age, sexual orientation, race, religion, creed, or ability, deserves to be treated with dignity and respect. Thank you for treating Outdoors for All participants, volunteers and staff the way you would like to be treated: with respect.

A person is a person first, not a condition or a feature. Any reference to a person's appearance, features, religion, age, gender, ability, etc, is appropriate only when the reference is pertinent to the conversation. A person with a disability may have some challenges that cause them to talk, walk, think or look differently from others. Most people with disabilities learn to accommodate for their differences and live the same type of life as anyone else; just as others have learned to accommodate for their left or right handedness, or wearing glasses or contacts.

To be more effective when working with your participants, you should be knowledgeable about the disability or disabilities that your participants may have. The more knowledge that you have about various disabilities, the better you will be able to assess each participant's individual needs.

## **Disability Information**

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This disability information is provided so that you can make informed decisions when working with Outdoors for All participants. The information presented here describes some *typical* characteristics of the different types of disabilities we may see as Outdoors for All volunteers.

Be aware that there is no such thing as a *typical* person. Please use the information here to understand the general nature of a person's disability, and as a guideline for assessing potential issues that may impact the participant's performance.

### **Categorizing Disabilities**

Disabilities are either congenital or onset later in life. A *congenital* disability is one that the person is born with, such as spina bifida or Down syndrome. People with a congenital disability only know what it's like to function with their current level of ability. An *onset* disability is one that a person acquires later in life, due to a traumatic injury or a disease after birth. Examples include multiple sclerosis (MS) or spinal cord injuries.

There are two primary types of disabilities: diseases and conditions. A *disease* is progressive and generally gets worse, resulting in an increasingly affected condition. Examples include diabetes, multiple sclerosis (MS), and muscular dystrophy. A *condition* is a fixed state of ability, which generally does not get worse. Examples include spinal cord injuries, cerebral palsy and intellectual disability. A person may benefit from therapy, but there are no existing means to cure a condition. Some disabilities may begin as a disease, such as cancer or polio, but become conditions when the progress of the disease is arrested.

We also discuss disabilities in reference to their physical, cognitive and/or sensory nature:

**Physical Disability** — A condition or disease that interferes with mobility or physical movement. Onset can be at birth or later in life, due to an accident or the onset of a disease. Examples include amputation, cerebral palsy, stroke, multiple sclerosis (MS), post-polio syndrome, spina bifida, spinal cord injury, head/brain injury. The following terms can help describe a physical disability:

Paresis — Partial loss of function.

Plegia — Complete loss of function.

Hemi — Affecting one side of the body (i.e. right leg and right arm).

Para — Affecting the lower extremities.

Quad — Affecting all four limbs.

**Cognitive Disability** — A wide group of conditions that involve cognitive delays as a result of damage to the brain. Cognitive disabilities are specifically classified as developmental disabilities if the condition appears during the first 18 years of life, with an indefinite duration. Cognitive disabilities can be caused by congenital abnormalities, trauma, disease and/or deprivation, and the origin can be organic (related to disease) or non-organic (caused by injury or trauma). Examples include autism, learning disabilities, Down syndrome, attention deficit disorder (ADD), intellectual disabilities, head/brain injury and stroke.

**Sensory Impairment** — A group of conditions or diseases that affects a person's ability to see, hear, smell, touch, taste, and understand spatial awareness. Examples include visual impairments (some vision), blindness (no vision), hearing impairments (some hearing), and deafness (total loss of hearing). Sensory Impairments are also common among people with Autism Spectrum Disorder, or other Pervasive Developmental Disorders- Not Otherwise Specified (PDD-NOS). When coupled with these types of disorders, Sensory Impairment most commonly presents as affecting touch, taste, and spatial awareness.

## **Disability Specific Information**

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### **Amputation**

An amputation is a condition involving the removal of a limb or portion of the body. A person may have an amputation for one of several reasons: amputation can result from injury (e.g., trauma or burns), disease (e.g., cancer or diabetes) or congenital limb loss (limb deficiency due to a developmental defect, often during pregnancy).

Amputations are characterized by the location of the amputation. Disarticulation refers to the removal of a limb at the joint.

Hip Disarticulation — Removal of the entire leg at the hip.

Above-Knee (AK) — Above the knee and below the hip.

Below-Knee (BK) — Below the knee and above the ankle. Leaves a functional knee.

Above-Elbow (AE) — Between the elbow and the shoulder.

Below-Elbow (BE) — Between the elbow and the wrist. Leaves a functional elbow.

Shoulder Disarticulation — Removal of the entire arm at the shoulder joint.

Unilateral Amputation — Multiple amputations on the same side, for example, BK and BE.

Bilateral Amputation — Multiple amputations equal on both sides, for example, double BK.

*Considerations:* Since amputees typically wear prosthetics, the type of prosthesis depends on the type of amputation. When working with your participant, make sure that the residual limb is protected from injury and the elements. Be aware that people who normally walk with prosthetics may have difficulty adjusting to participation in sports without their prosthesis. Watch for muscle fatigue.

Assess the participant to discover relevant information, such as when the injury occurred and whether there are any secondary conditions. Because a portion of the body is missing, balance issues may impact the participant's performance.

*Equipment:* If you or the participant have a difficult time getting their prosthetic foot into a ski or snowboard boot, consider using a plastic bag over the prosthetic foot to help it slide into the liner more easily. Depending on how an amputation or prosthetic affects the participant's balance, consider using poles or outriggers for stability. Make equipment adjustments to ensure that the participant is able to hold a flat ski with his or her prosthetic.

## **Cerebral Palsy**

Cerebral Palsy (CP) is a condition that affects a person's movement and posture. The condition is the result of brain damage (typically, a lack of oxygen) that occurs prior to, during, or just after birth. CP manifests in a variety of different ways, usually physical, and may include speech and/or cognitive impairment. The area and the degree of damage to the brain determines the individual's level of ability.

Typical characteristics of an individual with CP may include paralysis, weakness or the inability to coordinate motor function. Other aspects of CP may include abnormal muscle tone, a delay in normal development and/or abnormal reflex activity. Some people with cerebral palsy have difficulty with hearing, vision or speaking (dysarthria). CP is generally not associated with learning disabilities or intellectual disabilities. Individuals with CP may also experience seizures and abnormal sensation of the limbs, such as hypersensitivity or diminished sensitivity.

*Considerations:* If the person is non-verbal, ask the participant how he or she communicates. Ask the person to demonstrate how he or she says yes and no. If balance is an issue, the individual may need equipment adaptations or modifications to assist with balance and stability. In addition, many people with CP are unable to relax their limbs (due to muscle spasticity). Increased muscle spasticity can make falling more painful and potentially dangerous, so take extra care to avoid falls.

*Equipment:* If a participant has difficulty with their ski tips crossing or scissoring, consider using tip connectors or a ski bra. **\*Do not allow participants to ski backwards while using tip connectors!** If a participant has difficulty with balance on turn initiation, consider using outriggers. Remember to introduce equipment adaptations, such as tip connectors, with a short or long-term plan to phase them out of your lesson! Ideally, this equipment is a stepping stone that allows a participant to gain ownership of a certain movement or skill without assistance. Depending on a participant's individual diagnosis, he or she may use a bi-ski or mono-ski.

## **Intellectual Disability (ID)**

An intellectual disability limits a person's ability to learn at an expected level; it also affects a person's functional skills within their home environments. Intellectual disability can be caused by injury, disease or development of the brain before or after birth. Intellectual disabilities were formerly known as "mental

retardation," which is no longer an acceptable term (although you may continue to see this term used on some of our participant's Personal Information Forms).

*Considerations:* Use clear instructions, and break a task down into one component at a time. Work with the individual or caregiver to figure out how he or she learns best.

*Equipment:* If a participant has difficulty with their ski tips crossing or scissoring, consider using tip connectors or a ski bra. **\*Do not allow participants to ski backwards while using tip connectors!** Remember to introduce equipment adaptations, such as tip connectors, with a short or long-term plan to phase them out of your lesson! Ideally, this equipment is a stepping stone that allows a participant to gain ownership of a certain movement or skill without assistance.

## **Down Syndrome**

Down syndrome is a genetic disorder caused by an extra chromosome. Individuals with Down syndrome often experience cognitive delays, although the effects are typically mild to moderate. These cognitive delays may include characteristics such as poor judgment, a short attention span, impulsive behavior (including an inability to comprehend danger), and delayed language and/or speech development. Individuals with Down syndrome also may experience decreased or poor muscle tone, as well as excessive joint flexibility.

*Considerations:* Use clear instructions, and break a task down into one component at a time. Work with the individual or caregiver to figure out how he or she learns best. Be aware of impulsive or stubborn behavior, and watch for signs of fatigue. Many people with Down Syndrome learn best through memory, so repetitive movements may work best for teaching.

*Equipment:* If a participant has difficulty with their ski tips crossing or scissoring, consider using tip connectors or a ski bra. **\*Do not allow participants to ski backwards while using tip connectors!** If a participant has difficulty with coordination or following directions, consider using stand-up tethers to help build muscle memory. Remember to introduce equipment adaptations, such as tip connectors, with a short or long-term plan to phase them out of your lesson! Ideally, this equipment is a stepping stone that allows a participant to gain ownership of a certain movement or skill without assistance.

## **Attention Deficit Disorder (ADD) / Attention Deficit Hyperactivity Disorder (ADHD)**

Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder is a neurological syndrome that is usually hereditary. ADD is characterized by distractibility, short attention span, impulsiveness, hyperactivity, and restlessness that interfere with everyday function. ADHD is ADD combined with excessive activity and energy.

*Considerations:* Keep the individual engaged and focused by staying active! Individuals with ADD/ADHD often have a hard time sitting still to listen as you explain something. Make your lesson interactive, and encourage the person to learn by doing.

## **Autism Spectrum Disorders (ASD)**

Autism spectrum disorders are a group of neurological disorders characterized by communicational and behavioral impairments. Common characteristics of autism include repetitive mannerisms and limited

patterns of behavior, including obsessive resistance to change. Many individuals with autism have trouble understanding social cues and feel uncomfortable in social situations; this can include awkward or repetitive conversation, discomfort with touch, and inappropriate behavior.

ASD can be associated with intellectual disability, difficulties in motor coordination and attention. Some persons with ASD excel in visual skills, music, math and art.

*Considerations:* Use a calm, even tone of voice and give clear, succinct and direct instructions. Give the person ample time to respond before repeating instructions. Provide visual cues when possible (e.g., a thumbs up when the participant is doing well; pointing in the direction you want the participant to go). Avoid idioms and sarcasm when speaking, as many individuals with ASD take things literally. Having a schedule for the day and sticking to it also works well. Many people with ASD learn best through memory, so repetitive movements may work best for teaching.

If the individual becomes frustrated, or has a "melt-down," give him or her space and time to calm down. If the person becomes physically aggressive, keep yourself and others safe – stay out of the way. And do not feed into attention seeking behavior. Please work with your Lead Volunteer or the Program Manager to address any behavioral concerns.

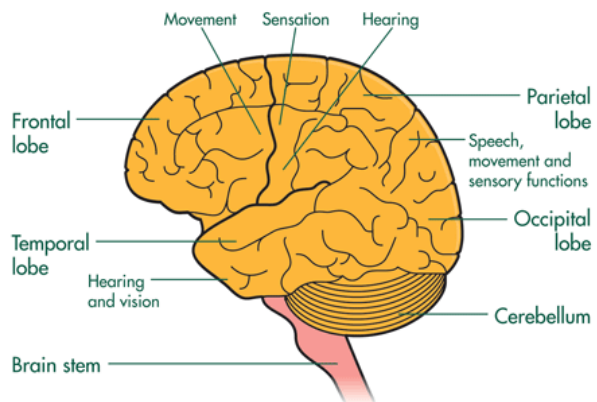
*Equipment:* If a participant has difficulty with their ski tips crossing or scissoring, consider using tip connectors or a ski bra. **\*Do not allow participants to ski backwards while using tip connectors!** If a participant has difficulty with coordination or following directions, consider using stand-up tethers to help build muscle memory. Remember to introduce equipment adaptations, such as tip connectors, with a short or long-term plan to phase them out of your lesson! Ideally, this equipment is a stepping stone that allows a participant to gain ownership of a certain movement or skill without assistance.

## Brain Injury

Brain injury can be caused by a variety of factors. Symptoms are determined by the section of the brain that is injured, and can vary greatly. Effects of a brain injury can be physical, cognitive, social, and/or emotional. Damage on one side of the brain tends to affect the opposite side of the body, and the degree of impairment depends on the portion of the brain that is injured. People with brain injuries often have a predisposition to seizures.

### The Brain

- Frontal Lobes — Thinking, speaking, basic movement, emotions, behavior, personality, judgment
- Parietal Lobes — Sense of touch, sense of pain, spatial perception
- Temporal Lobes — Hearing, memory
- Occipital Lobes — Vision



The two most common types of brain injury are:

**Stroke/Cerebral Vascular Accident (CVA)** — A stroke, or CVA, is a temporary loss of blood (and therefore oxygen) to the brain. Strokes are either *ischemic* (blockage of a blood vessel) or *hemorrhagic* (eruption/dissolution of a blood vessel).

**Traumatic Brain Injury (TBI)** — A traumatic brain injury is caused by non-organic events such as injury or trauma.

Common characteristics of brain injury include partial loss (hemiplegia) or complete loss (hemiparesis) of function or control of one side of the body. People with this condition often have balance issues and/or possible vision loss. Other common characteristics include lack of balance or coordination, limited agility and cognitive difficulties (including memory deficits, limited attention span and/or lack of judgment).

*Considerations:* Individuals with an acquired brain injury are often frustrated by what they can't, or can no longer, do. Be considerate, and support the person to accomplish his or her goals. Set realistic expectations, within a realistic time frame. If memory loss is of concern, write down important information or loop-in the individual's caregiver into your conversation. Be aware of their judgment in relation to safety awareness on the hill as that may have been affected as well.

*Equipment:* Depending on the participant's diagnosis, choose equipment that will support his or her individual needs. If a participant has difficulty with their ski tips crossing or scissoring, consider using tip connectors or a ski bra. **\*Do not allow participants to ski backwards while using tip connectors!** If a participant has difficulty with coordination or following directions, consider using stand-up tethers to help build muscle memory. Remember to introduce equipment adaptations, such as tip connectors, with a short or long-term plan to phase them out of your lesson! Ideally, this equipment is a stepping stone that allows a participant to gain ownership of a certain movement or skill without assistance.

### **Seizure Disorder (Epilepsy)**

Epilepsy is a disorder of the central nervous system marked by unusual electric activity in the brain that causes seizures. Seizures are sudden, brief changes in how the brain works: this causes partial or complete, brief or prolonged, lapses in consciousness. Epilepsy is a physical condition manifested by focal point, petit mal, or grand mal seizures. In many cases, there is no known cause of epilepsy.

Seizures usually last a short time (a few seconds), and can be either convulsive or non-convulsive. The most common types of seizures are:

- **Tonic-Clonic** (formerly Grand Mal seizure): The most dramatic type of seizure, characterized by loss of consciousness, rigidity, jerking of the extremities and falling. When a Tonic-Clonic seizure occurs, move the person to a quiet area or place the person in a comfortable position. Try to position the person on his or her side. Do not place anything between the person's teeth. Be comforting after the seizure.
- **Absence seizure** (formerly Petit Mal seizure): Characterized by a brief lapse of unconsciousness or awareness. Usually lasts only a few seconds, and may appear as a blank stare. As with other types of seizures, mental processes cease during an absence seizure. Other symptoms may include muscle twitching, rolling or blinking eyes, or visual fixation on one object. The person may not even be aware that a seizure is taking place.
- **Myoclonic seizure:** Rapid, brief jerks of arms or legs however the person usually still has awareness



- **Atonic seizure (drop attack):** Seizure that produces an abrupt loss of muscle tone

*Considerations:* Seizures can be brought on by a variety of factors, including fatigue, cold, stress or problems with medications. If possible, it's important to know any potential triggers for your participant's seizures. When a person has a seizure, keep calm and make sure that the person doesn't hurt themselves when they lose consciousness. Do not attempt to restrain a person while they're having a seizure. Make the person as comfortable as possible. After regaining consciousness, an individual may feel confused, disoriented and sleepy. During seizures many people lose continence. Make sure to be polite and discreet if someone needs to clean up or change clothes. Be sure to allow an individual to rest after a seizure.

*Equipment:* Please know the Outdoors for All seizure policy, and use a seizure retention strap when appropriate. When in doubt, talk to your Lead Volunteer or Program Manager!

## **Deaf or Hard of Hearing**

A hearing loss occurs when one or more parts of the ear or brain that are needed to process sounds become diseased or damaged, resulting in partial or total loss of hearing. Hearing loss can be caused by injury to the ear or brain. Damage to the middle ear can often be off-set by the use of a hearing aid. Damage to the inner ear or the brain is often more severe, and hearing aids may not be beneficial. Some people with hearing loss associated with the inner ear may also have balance issues. Speech impairments are a common secondary condition.

When talking about someone with hearing loss, it is more appropriate and respectful to use the term "hard of hearing" in lieu of "hearing impaired". "Hearing impairment" can imply that something is not as it should be, and ought to be fixed if possible.

*Considerations:* People with hearing loss may communicate in a variety of ways. Some methods of communication include reading lips, sign language or finger spelling. People with hearing loss often rely on facial expressions and body language to understand the conversation. Be sure to speak clearly and face the person when speaking. Do not over-enunciate words.

*Equipment:* Use high-visibility guide vests to help your participant to see you, and to help identify your lesson on the slopes.

## **Visual Impairment**

The most common causes of visual impairment in the United States are diabetes, myopic degeneration and glaucoma. Legal blindness is defined as corrected visual acuity of 20/200 or less. This means that at a distance of 20 feet, a person who is legally blind can see what a person with 20/20 vision can see at 200 feet. More than 90% of persons who are legally blind have some residual eyesight. Many can perceive light and can sense motion.

*Considerations:* When working with a person with a visual impairment, communication and guiding are two very important concerns. Speak to the participant so that he or she is aware of where you are. Use a normal voice and tone. Take the time to determine the level of sight the person has and ask how long the person has had the visual impairment. A person who has recently lost sight may have more balance issues or nausea. Determine whether the person has other secondary conditions, such as a brain injury.

When guiding, always ask the participant how he or she prefers to be guided. Be consistent and use clear communication. Remember, you are the person's eyes in an unknown environment.

*Equipment:* Use high-visibility guide vests to help your participant to see you (if they have any vision), and to help identify your lesson on the slopes. Consider using a bamboo pole to support kinesthetic learners. Use a two-way headset for better communication at higher speeds – this is particularly important for intermediate to advanced participants with little to no vision.

### **Post-Traumatic Stress (PTS)**

Post-traumatic stress (PTS) is a mental health condition that is triggered by either direct or indirect exposure to a traumatic experience. Symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event. Although often referred to as post-traumatic stress *disorder* (PTSD), it's important to understand that PTS is a *normal* response to an *abnormal* set of circumstances, and is therefore not a *disorder*.

Some common symptoms of PTS are psychophysical and emotional numbing/detachment, hyperarousal (irritability or constant alert for danger) and acting or feeling as if the event is recurring (flashbacks). Visual cues include irritable behavior or anger outbursts, trouble with concentration, hypervigilance (constantly "on guard") and an exaggerated startle response.

*Considerations:* As with any of our participants, ask before touching an individual with PTS. Avoid possible triggers, if possible – these might include crowds or loud and unexpected noises (such as avalanche explosives). If the participant has a flash back or an anxiety attack, give them space to remove themselves from the activity. Make sure that they're safe, then check-in after a few minutes. Don't hover, and when appropriate, ask how you can help them feel more comfortable.

### **Spinal Cord Injury (SCI)**

A spinal cord injury is a severe injury or disease to the spinal cord that causes partial or complete loss of sensation and loss of voluntary movement below the level of the injury. The injury is often caused by a broken bone of the vertebrae or a dislocation of the vertebrae. Typically, the higher up the injury occurs along the spinal cord, the greater the loss of function.

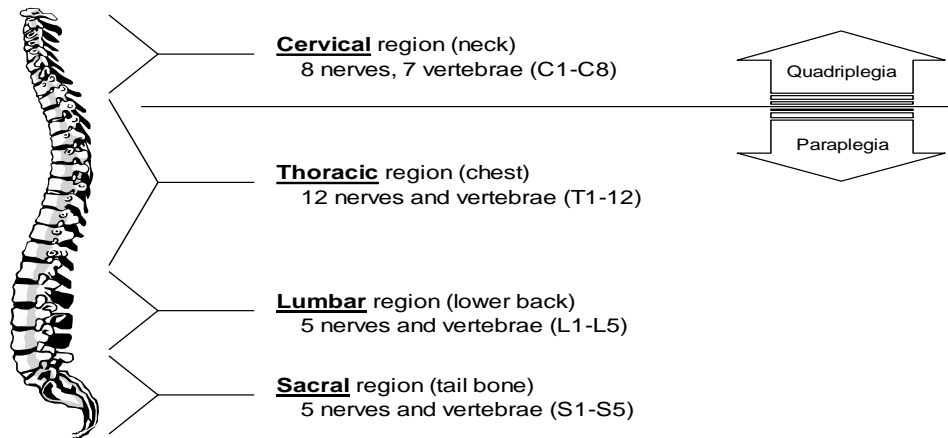
#### **The Spinal Cord**

The spinal cord is an extension of the brain and is composed of nerve cells and fibers. The spinal cord connects the brain to the nerves that control the body's muscles, skin and organs —it is the vehicle through which the brain communicates with the body.

Muscle movement begins in the brain as electrical impulses descend through the lateral and anterior parts of the spinal cord, through the spinal nerves and out to the muscles. When this motor pathway is injured, the result is a person's inability to move those muscles below the level of injury.

Sensation occurs when impulses travel from the skin or organs through the spinal nerves, up the spinal cord to the brain. When this sensory pathway is injured, the result is a loss of sensation below the level of injury.

The spinal cord is protected by the backbone, composed of bony structures known as vertebrae. The spinal cord is located in a canal that runs through the center of the vertebrae. There are four major sections of the spinal column.



Spinal cord injuries can be caused by disease (tumors, spina bifida) or by traumatic injury, and they are categorized by the area of the spine where the injury occurs. For example, an injury to the third vertebrae of the thoracic segment is known as T3 injury. Different areas of the spine are associated with specific functionality. Generally speaking, the higher the injury occurs along the spine, the greater the impact on person's functionality.

There are two common classifications of spinal cord injuries, determined by the level of impact:

**Paraplegia** — Injury of the lower spine (thoracic, lumbar or sacral) with partial or complete paralysis of the lower body, without involving the arms, shoulders, neck or head.

- L4 and below — Paralysis/paresis includes the lower legs, typically from the knees and below. Most people with a sacral or lower lumbar injury can walk with bracing and crutches.
- L1 through L3 — Paralysis/paresis now includes the lower extremities, including hip flexors, quadriceps and below. Many people with this level of injury can walk with bracing and crutches.
- T12 through T9 — Paralysis/paresis includes lower extremities and abdominal muscles. Trunk balance may be compromised. Most people with this level injury use a wheelchair. Upper body strength is not impacted by the injury.
- T8 through T2 — Paralysis/paresis now includes upper chest muscles and below. Trunk balance is compromised, which can impact dynamic balance. People with T8 and above almost always use wheelchairs that require additional support.

**Quadriplegia** — Injury of the upper spine (cervical, T1 and above) with partial or complete paralysis of the body involving both arms and legs. This level of injury may also involve shoulders, neck, head and respiration.

- T1 through C8 — Paralysis/paresis now includes intrinsic hand muscles. A person with a T1 injury and above is considered a quadriplegic (depending on the completeness of the injury) because all four extremities are now involved. At this level, the ability to hold things with the fingers is impacted.

- C7 through C5 — Paralysis/paresis now includes the fingers, hands and arms. Many people with this level of injury use powered wheelchairs because they lack the arm muscles necessary to propel a manual chair.
- C4 and up — Paralysis/paresis now includes the neck. People with this level of injury generally have movement limited to the head and neck. People with injury at this level often require devices to assist with breathing.

### **Potential Considerations Associated with Spinal Cord Injury**

- **Autonomic Dysreflexia:** Autonomic dysreflexia can be a life-threatening condition. Autonomic dysreflexia is a hypertensive (high blood pressure) crisis that can occur in people with a SCI above T6 level. Symptoms include sweating, gooseflesh, pounding headache and increased spasticity. It is caused by the body's inability to sense and react to specific stimuli, including such things as bladder distention from a kinked indwelling catheter or full leg bag, catheter irritation, skin pressure sores or spasticity from a stretched muscle.  
If autonomic dysreflexia occurs and is not managed correctly and immediately, it could lead to a stroke, coma or even death. Many individuals who could be prone to this condition are aware of the symptoms. Should symptoms occur, sit the person upright and loosen any straps to relieve excessive pressure on the skin. Help the participant check the urinary catheter or leg bag for kinks or plugs. Check for spasticity and relieve the muscle by decreasing the stretch on the spastic muscle.
- **Skin Sores/Pressure Sores:** Sores can develop in areas of insensitive skin, especially in areas of bony prominence such as ankles, knees, hips, sacrum, and ischium. Pressure sores are a very serious condition. Avoid prolonged pressure on the skin by performing weight shifts often. Be aware of improper positioning and check for pressure and pinching. Use adequate padding on bony areas.
- **Thermoregulation:** Many people with an injury of T8 or above are prone to impairments of internal temperature control. It is important to make sure that the individual is dressed appropriately, so that they do not become too cold or overheat.
- **Bladder functioning:** Be aware that many people with SCI have a tube (catheter) inserted into their bladder to deal with bladder control. The catheter connects to a plastic bag that attaches to the leg. People with SCIs are trained to deal with this issue. When working with a participant with an SCI, make sure adaptive equipment does not interfere with the leg bag and that the leg bag is placed in a position that will not cause pressure sores.

*Other considerations:* Many people with SCI use wheelchairs for mobility. Remember that just because the person is in a wheelchair, it does not mean there is anything wrong with the person's brain or hearing. A wheelchair provides a mechanism for moving around and becomes part of the person's "personal space." Never move, lean on, or touch a person's chair without permission. Always ask a person in a wheelchair how you can help before doing so.

*Equipment:* Depending on the participant's level of injury, consider using outriggers, the slider, a bi-ski or a mono-ski to support his or her individual needs. Be conscious of how equipment is fit, and use padding to avoid skin irritation or pressure sores. Consider using some type of grip assist for outriggers, if needed.

### **Spina Bifida**

Spina bifida is a birth defect of the spinal column and spinal cord. In this congenital condition, the spinal column fails to fully develop and close around the spinal cord, causing partial or complete paralysis below the level of injury. Individuals with spina bifida also may experience a disruption in the flow of

cerebrospinal fluid (CSF), which nourishes and cushions the brain and spinal cord. This disruption often results in a buildup of fluid and pressure in the head. A *shunt* may be used to relieve excess pressure in the brain. A shunt is typically located under the skin running from the base of the skull, down the side of the neck and across the chest, where the CSF is reabsorbed by the body. An individual with a shunt may not be able to ski with a helmet.

The symptoms of spina bifida are similar to a spinal cord injury at the level of the spinal cord exposure. The extent of an individual's impairment depends on the level of the exposure. Most instances of spina bifida occur in the lower spine, but it can occur at any level. The lower the level of exposure, the more lower-extremity function the person will have. In some cases, the person may be able to walk with bracing.

*Considerations:* Take special care to provide appropriate padding for the location of the spinal column defect. If necessary, place a donut-shaped pad around the tender area to provide protection. Individuals may also have a curvature of the spine, impacting the person's center of mass and resulting in balance issues.

People with spina bifida are often prone to skin problems caused by poor circulation. Make sure to take protective measures to avoid pressure sores, frostbite, excessive heat or cold, etc. Many people with spina bifida have extreme allergic reactions to latex. Duct tape, ace bandages and coban (vet wrap) frequently contain latex.

*Equipment:* Depending on the participant's diagnosis, consider using outriggers, the slider, a bi-ski or a mono-ski to support his or her individual needs. Be conscious of how equipment is fit, and use padding to avoid skin irritation or pressure sores.

## **Multiple Sclerosis (MS)**

Multiple Sclerosis is a progressive disease of the central nervous system in which the body's nerve fibers become scarred (sclerosed). The myelin sheath (insulation surrounding the nerves) allows messages from the brain and spinal cord to be sent throughout the body. Individuals with MS lose sections of myelin sheath along different portions of the nervous system, which in turn blocks the electrical impulses of the nerves. The scarring and deterioration of the myelin sheath can take place anywhere throughout the nervous system. Because MS can strike anywhere in the nervous system, the symptoms can vary widely, even with the same person.

MS is unique in its cycle of remissions, seeming to come and go over time. Symptoms can vary from day to day, and no two people have the same symptoms. MS is characterized by muscle weakness, chronic fatigue, balance problems, heat intolerance, and sometimes visual and cognitive impairments. Some people experience paralysis or weakness in their extremities, mood swings (lability) and slurred speech. Many people with MS have an unsteady gait and shaky movements of the limbs (ataxia).

*Considerations:* When working with a person with MS, watch for evidence of fatigue. Provide assistance as needed, and avoid unnecessary exertion. As symptoms can vary, it's important to have a continuing dialogue with the individual about his or her needs from day to day.

*Equipment:* Depending on the participant's diagnosis, consider using outriggers, the slider, a bi-ski or a mono-ski to support his or her individual needs. A participant may choose to use both stand and sit equipment during the course of one day, depending on his or her level of fatigue.

### **Muscular Dystrophy (MD)**

Muscular Dystrophy includes a group of hereditary disorders that are characterized by the progressive and irreversible wasting of muscle tissue. MD may include weakness of both voluntary and skeletal muscles, which control movement. The degeneration of the muscle tissue originates within the muscle tissue itself (compared to MS where muscle atrophy is the result of neurological defects).

Most types of MD appear by early adulthood, and are more common in males than females. The most common type of MD is Myotonic MD, which has a very slow progression and affects the central nervous system, eyes, heart, and endocrine glands. Duchenne MD, the second most common type, affects children (usually boys) and is often fatal (usually in the 20s).

The various types of MD have different symptoms; however, all typically experience a progressive loss of muscle tone. The muscles first affected are usually the pelvic girdle and upper legs, then the shoulder girdle and arms. People with MD may walk with the aid of crutches or a cane, although eventually most require a wheelchair.

*Considerations:* Because of the lack of muscle tone, the person's joints may be more susceptible to injury. Strength, endurance and balance may be issues impacting performance. When working with a person with MD, watch for evidence of fatigue. Provide assistance as needed, and avoid unnecessary exertion.

*Equipment:* Depending on the participant's diagnosis, consider using outriggers, the slider, a bi-ski or a mono-ski to support his or her individual needs. A stand participant with low muscle tone may benefit from the use of a tip connector or ski bra. **\*Do not allow participants to ski backwards while using tip connectors!** Remember to introduce equipment adaptations, such as tip connectors, with a short or long-term plan to phase them out of your lesson! Ideally, this equipment is a stepping stone that allows a participant to gain ownership of a certain movement or skill without assistance.

## **Working with People with Disabilities**

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### **Language**

Language can be inappropriate, negative and demeaning. If information about a disability is pertinent, then use language such as "person with a mobility impairment" or "person who uses a wheelchair." Notice how we choose to put the *person* first, and then any information about his or her disability.

Old Terminology	Acceptable Terminology
Handicapped	Person with a disability or person who is disabled.
Afflicted/Stricken-With	Person who has ____.
Victim	Person who has survived ____.
Crippled	Person with a mobility impairment. Person who uses ____.

Retarded/Retard	Person with a developmental disability.
Lunatic/Nuts/Crazy	Person with a mental illness.
Deaf and Dumb	Person who is deaf and mute.
Normal	Person without a disability. Able-bodied.

## **Enable Ability**

Appreciate what people *can* do. The difficulties a person faces often stem more from society's attitudes and barriers than from the effects of their impairment. Focus on *ability*, and use the participant's strengths to compensate or adapt.

Respect the person's right to indicate the kind of help he or she wants. Give assistance, if asked; if the need seems obvious, offer assistance before helping. Do not give unwanted assistance and never insist. Usually a simple statement such as, "*let me know how I may help,*" opens up communication without making either party feel awkward or dependent. When someone does indicate desire for assistance, ask *how* you may help. For example:

Ask a person with a visual impairment to show you how he or she wants to be guided.

Ask a person using a wheelchair to tell you how you could assist with their transfer.

A person with a visual impairment can usually hear without difficulty, so you need not yell. An adult with an intellectual disability is not a child, so you may speak to him or her as you would any of your adult friends. A person using a wheelchair does so because his or her legs do not allow bipedal mobility, not because he or she cannot understand, hear, or see. People in wheelchairs are not confined; rather, wheelchairs liberate by allowing mobility. The wheelchair is part of his or her personal space, so do not lean on the person's "legs" without permission.

When working with a participant in an activity, always allow the person to experience as much *independence* as possible. Do not assume our participants cannot do something simply because of a disability.

## **Conversing**

If it comes up naturally, or if you need to know something specific, feel free to ask about the participant's disability. Let the participant, or his/her significant others, guide you. Be respectful and sensitive, and focus your questions on information that is pertinent to the activity. For example, ask "Can you describe your vision to me?" instead of "How did you lose your eyesight?"

Speak directly to a person with disability, even if they have an interpreter, companion or attendant. Explore your mutual interests and conversational topics just as you would with any new acquaintance. People with disabilities have much more to discuss than their impairments!

Common societal expressions are acceptable, for example, "Did you see that movie?" or "Let's take a walk." People with disabilities do not usually desire different treatment. Along that line, they also do not want someone to be condescending. Talk to people with disabilities just as you would to anyone their age.

People who have visual impairments use other senses to take in environmental information. Ask him/her if s/he would like you to describe the scenery, explain who else is around, or if s/he would like to hold or touch an object you are explaining. When directing him/her from a distance, use directions or your voice. For example, say "*Come over this way toward my voice*" or "*Just a little to the right.*" If you do use your voice as a guide, remember to keep talking.



Be patient with those who have difficulty speaking. Do not finish sentences or answer for participants. When you do not understand something said, ask them to repeat themselves. Try repeating what you thought you understood. They will tell you whether you are correct and repeat what you did not understand. Do this as often and as much as you need. Ask him/her to rephrase if you feel you cannot understand a word or sentence.

If the person cannot verbally communicate, it does not mean that they don't have other ways of communicating. Ask a parent or guardian how they communicate at home. They could use Picture Exchange Communication System (PECS- pictures to display feelings/tasks/needs), To-Do/Done Boards, First/Then boards and/or many more. Before leaving their parent and guardian make sure you at least know how they communicate "yes" and "no", and then you can use yes/no questions to communicate, while learning their unique communication system.

Slow your rate and speak calmly without yelling or exaggeration to a person with a hearing impairment. Be sure they can see your face and use gestures or other methods of communication. Ask him/her to show you commonly used gestures so you may use them also.

It is OK to say no to a person with a disability, just as you might to anyone else. You are welcome to set your comfort limits that do not interfere with others' rights. For example, if a person with a disability invades your personal space, you can tell them not to. With some people, you may have to be repetitive.

People with disabilities are not necessarily special, inspirational or courageous. They are people, making the best of their situations — just like you. They usually do not want to be patronized or put on a pedestal — just like you. They just want to be accepted, supported, encouraged, praised, and loved — just like you.

Treat a person with a disability as you would anyone you know.  
Treat them as you would want to be treated by others.

### **Participant Evaluation**

The participant, with assistance from you and the participant's significant others, determines his/her strengths and participation considerations. You, with input from the participant as to his/her goals, develop a plan to assist him/her to participate using his/her strengths and adapting, as needed, for areas of consideration. **In all cases, strive for minimum adaptation to achieve maximum participation and fun.** Use the following method to assist you in this process:

- Obtain and read the individual's Participant Information Form (PIF) through Outdoors for All. Contact the participant, and/or significant others, before the activity for specific questions and/or information. **This is a great time to ask about his/her goals for the activity.**
- Observe the participant interacting with you and others, moving around, putting on equipment, during lessons, etc. Your observations will assist you greatly in determining how to best work with your participant. Continue to ask him/her about his/her goals as they may change.
- Let the participant guide you. Most individuals will offer reliable information and know their compensations. Exceptions may be those with cognitive or behavioral impairments; you may need to confirm information with significant others.
- Perform simple tests and ask questions with the participant. Examples are testing for basic muscle strength (offer your hand for a handshake), and asking questions to determine understanding of

complex information or memory (ask what they remember about their lessons last season). If in doubt, ask your Lead Volunteer or Program Manager for assistance.

- Talk with significant others, if needed. Significant others may include family, friends or staff. They can confirm and add information.
- Talk with volunteers who know the participant. Read previous progress reports.
- Talk with Lead Volunteers. They can direct you to resources and advise you on tips, adaptive equipment and teaching methods. Ask them for any assistance you need. Their job is to help you to do your job!

### **Behavior Management Suggestions**

All behaviors happen for a reason – although, sometime, that reason can be difficult to determine. Determining the *why*, or the *function*, for any behavior is an important step towards positive behavior management. Most behaviors occur for one of four reasons:

- *Escape or Avoidance*: An individual might engage in self-injurious or challenging behavior to avoid a certain situation, task or person.
- *Social Attention*: An individual might engage in behavior that draws attention to them – they want someone to look at them, talk to them, laugh at them, or even scold them. They may act out to receive “bad” attention, instead of no attention at all.
- *Tangibles or Activities*: An individual might scream and cry until they get a specific item, or are allowed to engage in a specific activity.
- *Automatic or Sensory Stimulation*: An individual might engage in a self-stimulating behavior that either results in a pleasing sensation or relieves a displeasing sensation (ex: pain). In either case, this type of behavior does not rely on an external factors.

The following suggestions may be helpful when working with someone to manage difficult or inappropriate behavior. When in doubt, please work with your Lead Volunteer or Program Manager for support!

- You are the role model – model positive and appropriate behaviors. Reinforce positive behaviors, and ignore undesired attention-seeking behaviors.
- Be clear, concrete and concise about your expectations to the individual, and determine his/her expectations of you.
- Offer choices and/or use a visual schedule. Cue transitions.
- Redirect the individual to alternative, positive behaviors that have the same *function*. For example, an individual could tap the keys on a piano, instead of tapping the table.
- Be compassionate. Give ample encouragement to participate and behave appropriately. All encouragement should be age-appropriate and respectful.
- Identify an individual’s successes, and encourage appropriate self-praise.
- Be consistent.

### **Medications**

Many of our participants will be taking a variety of medications. Many medications have potential physical and/or cognitive side effects that you should know about. Be sure to consult your participant's Personal Information Form to determine if their medications have side effects that may impact the student's performance.

Not every person experiences side effects in the same way. When possible, consult the participant or participant's caretaker for more information about whether the participant has side effects that may impact performance.

During the evaluation of your participant, find out about the participant's medication schedule. You might need to remind your participant to take their medication, but NEVER administer medication to a student!

## **Additional Resources**

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The field of adaptive snow sports is constantly evolving. For more information about disability awareness and/or adaptive equipment and instruction, please take some time to peruse the following resources.

- Outdoors for All's online training library provides links to a variety of different resources for Alpine, Nordic and Snowboard Instructors: [www.outdoorsforall.org/get-involved/training/](http://www.outdoorsforall.org/get-involved/training/)
- PSIA-NW is the local, divisional resource for information about clinics, exams and continuing education: [www.psia-nw.org](http://www.psia-nw.org)
- The PSIA-AASI national website contains additional information about the growing field of adaptive skiing and snowboarding: [www.thesnowpros.org](http://www.thesnowpros.org)

## Adaptive Equipment

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### Mono-Ski

Mono-skis consist of a bucket-style seat with suspension, and a single ski attached underneath it. Participants use hand-held outriggers (metal elbow crutches with small skis attached to the ends) to assist with balance and turning. Individuals who have lower limb impairments, as well as reasonable balance and trunk stability, are generally good candidates for mono-skiing; this may include people with traumatic brain injuries, spinal cord injuries, muscular dystrophy, cerebral palsy, multiple sclerosis, spina bifida, post-polio and double amputations.



Mono-skis are designed to be skied independently, and are not typically “tethered” by the instructor.

Outdoors for All has a selection of different mono-skis, including both adult and youth sizes.

### Dual Ski



Dual skis are relatively new to winter adaptive sports. They resemble a bi-ski, though they ski more like a mono-ski. The dual ski is an excellent fit for individuals who have an injury level that prevents them from successfully skiing a mono-ski, but who are limited by the performance of a Bi-Unique or Mountain Man.

An advantage to the HOC Glide and Tessier Dual ski is that it can be skied independently. The user is able to load and unload chair lifts without support, and also ski without being tethered by an instructor. Like a mono-ski, the HOC and Tessier both feature adjustable spring shocks and compression for advanced fitting and tailored performance.

Fixed outriggers cannot be attached to either the HOC or Tessier. The user must have good trunk

stability, along with enough coordination and strength to use handheld outriggers.

Dual skis are available in adult sizes only.

## Bi-Ski

Bi-skis consist of a bucket-style seat with two skis underneath it. Participants may ski independently using hand-held outriggers (metal elbow crutches with small skis attached to the ends), or they may ski with fixed outriggers and the assistance of an instructor on tethers (webbing lines attached to the back of the bi-ski); participants may also ski with hand-held outriggers and the assistance of an instructor on tethers. Bi-skis are designed for individuals who need more assistance with balance and speed-control out on the snow. Individuals with mid- to high-level spinal cord injuries, cerebral palsy, multiple sclerosis, spina bifida, muscular dystrophy, multiple amputations or other balance impairments are generally good candidates for bi- skiing.



The Bi-Unique (pictured above) is a faster, more aggressive ski. It does not have any shock absorbers, and being connected directly to the ski bindings, allows the ski to be very responsive. The Bi-Unique also features a steep sitting angle, allowing for a tighter, more aggressive fit. The hand pump allows for easy loading, and this ski can be used to ski independently on the mountain.

The Mountain Man (pictured at left) is a staple in Outdoors for All's sit-ski programs. It's easy sitting angle, padding, and supportive seat allows any participant to ski in the Mountain Man. The Mountain Man has an adjustable air shock for a gentle ride.

Both Bi-Uniques and Mountain Mans are available in youth and adult sizes.

## 4-Track Skiing and Snow Slider



4-Track skiing is stand-up skiing with two skis and two hand-held outriggers; this type of skiing gives the skier four points of contact with the snow, allowing for the skier to more easily compensate for any balance impairments. Hand-held outriggers are metal elbow crutches with skis attached to the ends. Individuals with cerebral palsy, multiple sclerosis, post-polio, spinal cord injuries, strokes, muscular dystrophy, spina bifida, or those with strength and/or balance issues, may be strong candidates for 4-track skiing.

The Snow Slider (pictured above) is another form of 4-track skiing for those with more profound strength and/or balance issues. The Snow Slider consists of a metal frame with skis mounted underneath, making it similar to a walker with skis. Participants ski with the assistance of an instructor on tethers (webbing lines attached to the Slider), who may assist with turning and speed control.

Hand-held outriggers are available in all sizes to allow adults and youth to ski in a standing position with some balance support. The Snow Slider is available in both youth and adult sizes.



### 3-Track Skiing



3-Track skiing is stand-up skiing with one ski and two hand-held outriggers (metal elbow crutches with skis attached to the ends), giving the skier three points of contact with the snow. 3-Track skiers must have one strong leg and two strong arms, so individuals with above-the-knee amputations or single lower limb weakness frequently use this method of skiing. 3-Track skiing requires a certain level of both leg and arm strength, and it may not be a good fit for those who are in poor physical condition.



## 2-Track Skiing



2-Track skiing is suitable for any participant who can stand on two skis without the support of hand-held outriggers. Participants must be able to stand and maintain balance while in motion, although adaptive equipment such as tethers (pictured below), spacer bars or tip-connectors (pictured below) may be used to assist with turning and coordination. 2-Track skiing is often well-suited for participants with developmental disabilities, cognitive disabilities or mild cerebral palsy.



## Snowboarding



Although choosing between 2-Track skiing and snowboarding is often a matter of personal preference, snowboarding can be a particularly good option for participants with lower or upper limb amputation. Participants with balance impairment, or who have difficulty turning, may also snowboard with outriggers or with an instructor on tether.

### **Visual and Hearing Impairments**

Individuals with visual or hearing impairments can learn to ski or snowboard with the assistance of a trained guide. Some participants choose to ski with a two-way communication device, to better hear their guide and/or instructor. Participants with visual or hearing impairments typically use standard 2-track or snowboard equipment, unless they need the additional support of specialized adaptive equipment.





## Seizure Belt



Seizure belts are mandatory for participants who have a history of grand mal seizures in the past 24 months. The belt is worn to secure a participant to the chair lift, which prevents the participant from falling off the chairlift, in the event of a seizure.

The seizure belt is a certified rescue belt designed to bear weight in case of a fall. While riding a chair lift, a tether and non-locking carabineer attach the seizure belt to the chair lift

## Nordic Skiing and Snowshoeing



Nordic skiing and snowshoeing are suitable activities for any participant who is interested in enjoying some aerobic exercise during the winter months. Both Nordic skiing and snowshoeing allow participants to explore local trails at their own pace. A Nordic ski "walker" (pictured left), similar to the Snow Slider, is available for participants with balance impairments.

Sit Nordic skiing (pictured right) is available for participants with lower limb impairments. This type of equipment consists of a bucket-style seat with two Nordic skis underneath it. Participants propel themselves forward with two modified Nordic ski poles.

Skiers must have arm strength to push themselves with ski poles in the snow. The Nordic ski is skied in standard xc ski tracks. If the skier needs assistance, instructors may be tethered in front to help pull the ski, or can be tethered behind to act as a brake assist.



The Nordic sit-ski is available in adult sizes only.