STAYCATION PARTICIPANT APPLICATION FORM

Thank you for your interest in Staycation! Please carefully read and complete all areas of the application form.

PARTICIPANT INFORMATION

First Name_____ Last Name_____

Nickname/ Preferred Name_____

Address_____

Birthday (mm/dd/yy)_____ Phone#_____

Email_____ Primary Language_____

What is your living arrangement? _____

Are you legally under the care of a guardian(s)? ☐ Yes ☐ No

If under guardianship, please provide guardian's information.

Name_____ Relationship to applicant_____

Address_____

Primary #_____ Alternate # _____

Who is completing this application? ☐ Participant ☐ Other

If other, please provide the name and relationship to the applicant.

Name_____ Relationship to applicant_____

How did you hear about Staycation?_____

How will you get to and from our meeting or activity location?

☐ Access Transportation Access ID No._____

☐ DART DART ID No._____

☐ Hopelink ☐ Public transport ☐ Drive my own vehicle

☐ Ride By whom_____

EMERGENCY CONTACT

Please provide TWO individuals (other than the guardian listed above), Needs of the Community Society via Staycation may contact or turn the participant over to, in case of an emergency.

Name_____ Relationship to applicant_____

Primary #_____ Alternate # _____

Name_____ Relationship to applicant_____

Primary #_____ Alternate # _____

MEDICAL INFORMATION

Primary Physician_____ Phone#_____

Physician Address_____

Primary Diagnosis_____

Secondary Diagnosis_____

Insurance Provider_____ Insurance #_____

TREATMENT RECORD

	Most recent date	Reason	# Of visits the past 12 months
Doctor			
Emergency			
Hospitalization			
Surgery			

GENERAL MEDICAL HISTORY

Please check all of the applicable medical conditions.

☐ ADD/ ADHD
☐ Appendicitis
☐ Asthma
Severity:
☐ Mild ☐ Moderate ☐ Severe
Do you require an inhaler? ☐ Yes ☐ No
☐ Anxiety
☐ Bronchitis
☐ Car/ Motion Sickness
☐ Constipation
☐ Chicken pox
☐ Diabetes
☐ Ear infections
☐ Eczema/ Rash
☐ Epilepsy
☐ Frequent Colds
☐ Fainting
☐ Other condition(s)
Please specify_____

☐ Hay Fever/ Seasonal allergies
☐ Heart condition
☐ Hepatitis
☐ Hypertension
☐ Immunodeficiency
☐ Kidney or Urinary Tract Infections
☐ Measles
☐ Headaches/ Migraines
☐ Mumps
☐ Seizure
Date of last seizure_____
Type_____
Frequency_____
☐ German measles

ANATOMY/ DEVICES

Please check all the applicable anatomy/ devices.

☐ Wheelchair
☐ Splint/ Brace
☐ Contacts
☐ J-pouch
☐ Ostomy
☐ Other_____

☐ Crutches/ Cane
☐ Artificial limb
☐ CPAP
☐ G-Tube
☐ Feeding tube

☐ Walker
☐ Glasses
☐ Insulin pump
☐ Oxygen

ALLERGIES

☐ NONE

	ITEM(S)	TYPICAL REACTION	TREATMENT
MEDICATION			
FOOD			
OTHER			

CURRENT MEDICATION SCHEDULE

Please list all medications and supplements, including over the counter items, with as much details on this form.

NAME	STRENGTH/CONC.	BREAKFAST	LUNCH	DINNER	BEDTIME
EXAMPLE DRUGE A	*10MG*	*1 PILL 10AM ON EMPTY STOMACH*	*1 PILL WITH LUNCH AROUND 1PM*	*1 PILL WITH FOOD NO LATER THAN 7PM*	*2 PILLS PRIOR TO BED*

Please provide any additional information or directions if required.

LEVEL OF ACTIVITY

Can you comfortably walk 4 city blocks without requiring rest? ☐ Yes ☐ No
Please provide any additional information or comments.

_____

_____

_____

_____

LEVEL OF ASSISTANCE

Do you require 1:1 support: ☐ All day ☐ Parts of the day ☐ No

Please check all the appropriate boxes.

	Independent	Require Reminders	Moderate Assistance	1:1
Daily Care (ie. Dressing, brushing teeth)	☐	☐	☐	☐
Bathing/ Showering	☐	☐	☐	☐
Meals	☐	☐	☐	☐
Toileting	☐	☐	☐	☐
Medication Intake	☐	☐	☐	☐
Please provide any additional information or comments.				

PARTICIPANT PROFILE

How often do you partake in day or weekend programs away from home?

_____

Please share some of your interests.

_____

Please briefly describe your personality.

_____

_____

_____

BEHAVIOR

Please indicate all applicable behaviors.

- ☐ Punching/ Hitting
- ☐ Running
- ☐ Self injurious behavior
- ☐ Other_____
- ☐ Sensitivity to noise
- ☐ Homesickness
- ☐ Require high level of attention
- ☐ Risk to others
- ☐ Easily frustrated
- ☐ Drugs and Alcohol

What causes the behavior(s) indicated above? Please be as specific as possible.

_____

_____

_____

What methods/ techniques help de-escalate, re-direct or prevent this behavior?

_____

_____

_____

_____

BEDTIME

(Do not need to fill out if this is a day program)

☐ Difficulty walking ☐ Bedwetting ☐ Nightmares
☐ Fear of dark ☐ Sleep walking ☐ Difficulty falling asleep
☐ Snoring ☐ Talks in sleep

☐ Other_____

Please provide any additional information, comments and helpful routines that are helpful.

_____

_____

_____

FOOD/ DIET

(Do not need to fill out if this is a day program)

Please describe your eating habits.

☐ Selective ☐ Average ☐ Easy

What is your favorite meal?_____

Do you have any dietary restrictions? ☐ Yes ☐ No

If yes, please provide your restrictions.

_____

_____

PHOTOGRAPHIC RELEASE

I consent and authorize Needs of the Community Society via Staycation to take photos and/or videos of the above name participant during activities. I understand that the resulting materials may be used for purposes of travel, identification and for distribution or informational presentations about Needs of the Community Society and Camp Without Borders on our website and brochures.

_____ Initial here if you **DO NOT** consent to the photographic release.

Please email completed form to zac.gannett@nocsociety.org