

2010 Conference Guest Application

Instructions for Completion of This Application:

It is **imperative** that this application be filled out accurately and completely for the applicant. Completed applications are to be returned to Horizon Conference for review by Conference Administration before acceptance of the applicant. All information given will enable our staff to provide the applicant with care similar to what they are accustomed and will help to ensure a safe, pleasant experience while at conference. Christian Horizons shall maintain and safeguard the following information in a manner consistent with the confidentiality requirements of 1973-PA 116 & 218.

PERSONAL DETAILS:			Date: / /
Name:	First: _____	Middle: _____	Last: _____
Address:	Street: _____	Apt #: _____	
	City: _____	State: _____	Zip Code: _____
	Phone: () _____	E-mail: _____	Fax: () _____
Date of Birth:	MM/DD/YY / /	Gender: _____ M / F	Preferred Name: _____

PLACE OF WORSHIP (this information is collected for staff recruiting purposes):			
Name of church:	_____		
Address:	Street: _____		
	City: _____	State: _____	Zip Code: _____
Contact Name:	_____		Phone () _____

PRIMARY CONTACT:			
Name of organization/ Association:	_____		Relationship to Guest:
Contact Name:	First: _____	Last: _____	
Address:	Street: _____	Apt#: _____	
	City: _____	State: _____	Zip Code: _____
	Phone : () _____	Cell: () _____	E-mail: _____
Are you at home while guest is with us? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not sure			
If no, please include your phone number while away and dates you plan to be away:			

SECONDARY EMERGENCY CONTACT:			
Contact Name:	First: _____	Last: _____	
Relationship to guest:	_____		
Address:	Street: _____	Apt#: _____	
	City: _____	State: _____	Zip Code: _____
	Phone : () _____	Cell: () _____	E-mail: _____
Are you at home while guest is with us? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not sure			
If no, please include your phone number while away and dates you plan to be away:			

NOTE TO GROUP HOME ADMINISTRATORS: If you plan to close your home for the week that you send your people to conference, you must provide alternate names, addresses and phone numbers of persons that will provide care for your residents in case of emergencies.

DIAGNOSIS AND COMMUNICATION:.				
Diagnosis: (check all that apply)				
<input type="radio"/> None	<input type="radio"/> Autism	<input type="radio"/> Developmental Disability	<input type="radio"/> Brain or neurological damage	<input type="radio"/> Cerebral Palsy
<input type="radio"/> Deafness	<input type="radio"/> Epilepsy or Seizures	<input type="radio"/> Blindness	<input type="radio"/> Other (please specify): _____	
Based on the above, what is the primary diagnosis of the applicant? (list one)				
Does the guest have any physical limitations? Describe				
Does the guest use:				
<input type="radio"/> Manual wheelchair	<input type="radio"/> Electric wheelchair			
<input type="radio"/> Crutches	<input type="radio"/> Walker	<input type="radio"/> Cane		
Does the guest require assistance for transfers? <input type="radio"/> 1 Person <input type="radio"/> 2 People <input type="radio"/> Mechanical Lift <input type="radio"/> Independent				
Is the guest able to use a top bunk? <input type="radio"/> Yes <input type="radio"/> No				
Is the guest's speech understandable? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Somewhat				
Does the guest use:				
<input type="radio"/> Sign Language	<input type="radio"/> Bliss	<input type="radio"/> Other		
Does the guest:				
Read?	<input type="radio"/> Full sentences	<input type="radio"/> Single words	<input type="radio"/> Does not read at all	
Write?	<input type="radio"/> Full sentences	<input type="radio"/> Single words	<input type="radio"/> Does not write at all	
Does guest use:				
<input type="radio"/> Glasses	<input type="radio"/> Hearing aid			

ASSISTANCE:				
I – Independent	R – Reminders Only	V – Verbal Prompting	H – Hand Over Hand Assistance	F – Full Assistance
<input type="checkbox"/> Dressing	<input type="checkbox"/> Showering	<input type="checkbox"/> Washing hair	<input type="checkbox"/> Brushing hair	<input type="checkbox"/> Deodorant
<input type="checkbox"/> Shaving	<input type="checkbox"/> Brushing teeth	<input type="checkbox"/> Using toilet	<input type="checkbox"/> Menstrual hygiene	<input type="checkbox"/> Incontinence supplies
(If needed, sufficient incontinence supplies to last entire camp must be sent with guest.)				
Does guest usually shower: <input type="radio"/> Morning <input type="radio"/> Night				
Level of support recommended (please take into account the active nature of being at camp.)				
<input type="radio"/> 3 guests: 1 counselor <input type="radio"/> 1 guest: 1 counselor (additional cost)				
Please explain:				
Is routine extremely important to this applicant? <input type="radio"/> Yes <input type="radio"/> No				
If yes, please list his/her daily routine below and on the back of this sheet. We cannot promise to follow each guest's exact routine, but will do our best to attend to each guest's needs in this area.				

DIET:				
Assistance needed at meal times:				
<input type="radio"/> Fully independent	<input type="radio"/> Need food cut	<input type="radio"/> Needs food pureed	<input type="radio"/> Uses drinking straw	
<input type="radio"/> Uses adapted utensils (please send with guest)		<input type="radio"/> Needs to be fed by staff		
Does the guest have any eating or food-related disorders? <input type="radio"/> Yes <input type="radio"/> No				
Please indicate the disorder: <input type="radio"/> Diabetes <input type="radio"/> Prader-Willi <input type="radio"/> Other:				
Severity:				
Does the guest have any food allergies or dietary restrictions that need to be monitored by staff? <input type="radio"/> Yes <input type="radio"/> No				
Please list food allergies and what will occur if food is consumed, food restrictions or special diet requirements.				
If guest is on a weight-loss program or has diabetes, please indicate what sort of snacks, desserts, etc. are allowed.				
We are unable to monitor caloric intake.				
Should caffeine drinks be avoided? <input type="radio"/> Yes <input type="radio"/> No				

SOCIAL/BEHAVIORAL CONSIDERATIONS				
Has the guest been away from home before?		<input type="radio"/> Yes – length of time	<input type="radio"/> No	
Does guest have unusual sleep habits:		<input type="radio"/> Bed wetting	<input type="radio"/> Waking during night	<input type="radio"/> Other _____
How long can the guest be left alone safely?		Length of time		
Does the guest enjoy swimming?		<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Shallow <input type="radio"/> Deep
Lifejacket required?		<input type="radio"/> Yes	<input type="radio"/> No	
What recreational activities does the guest presently enjoy?				
How do they participate?		<input type="radio"/> Willingly	<input type="radio"/> With encouragement	<input type="radio"/> Seldom <input type="radio"/> Never
Does the guest have any significant fears?		<input type="radio"/> Yes	<input type="radio"/> No	
If yes, please list and describe how we can help.				
How does the guest:	Respect the privacy of others?	<input type="radio"/> Good	<input type="radio"/> Fair	<input type="radio"/> Poor
	Initiate interaction with others?	<input type="radio"/> Good	<input type="radio"/> Fair	<input type="radio"/> Poor
	Interact in a group	<input type="radio"/> Good	<input type="radio"/> Fair	<input type="radio"/> Not at all
	Tolerate frustration?	<input type="radio"/> Tolerates	<input type="radio"/> Withdraws	<input type="radio"/> Cannot tolerate, loses control
	Problem solve?	<input type="radio"/> Independent	<input type="radio"/> Some assistance	<input type="radio"/> Full support needed
	Adapt to change?	<input type="radio"/> Adapts	<input type="radio"/> Withdraws	<input type="radio"/> Cannot adapt, loses control
Describe the guest's:	Knowledge of basic manners	<input type="radio"/> Good	<input type="radio"/> Fair	<input type="radio"/> Poor
	Consideration of others	<input type="radio"/> Good	<input type="radio"/> Fair	<input type="radio"/> Poor
Describe the guest's orientation:				
<input type="radio"/> Aware of person, place, time, situation <input type="radio"/> Generally aware but inconsistent in 1 or 2 areas <input type="radio"/> Unaware of person, place, time, situation				
Does the guest engage in behaviors that require you to intervene?		<input type="radio"/> Never	<input type="radio"/> Rarely	<input type="radio"/> Frequently
Describe the behavior: (severity, frequency, cause and early warning signs)				
How do you typically intervene in these instances?				
Have there been any behavioral changes in the last year? Please describe, if any:			<input type="radio"/> Yes	<input type="radio"/> No
Is the guest on medication that controls or alters behavior?			<input type="radio"/> Yes	<input type="radio"/> No
Does the guest use medication on an as needed (PRN) basis to manage behaviors? (Please include details on MAR sheet and ensure medication accompanies guest)			<input type="radio"/> Yes	<input type="radio"/> No
What change to behavior does medication facilitate?				

MEDICAL INFORMATION:	
Is guest subject to seizures?	<input type="radio"/> Yes <input type="radio"/> No Frequency and type:
(If guest is on medication to control seizures, please ensure full details are included on MAR sheet and medication accompanies guest.) Describe a typical seizure: (movement, length, plan of action after seizure, expected behavior before and after, etc.)	
When should 911 be called?	
Do you require a record of seizures?	<input type="radio"/> Yes <input type="radio"/> No
If yes, how detailed?	
Allergies: (note severity; i.e. foods, medicines, plants)	
Intervention for allergic reaction: (e.g. Benadryl, epi pen, hospitalization, etc.)	
Is the guest a Hepatitis B Carrier?	<input type="radio"/> Yes <input type="radio"/> No
What is the guest's weight?	
Please comment on any other conditions/communicable diseases which present a health hazard.	

SEXUALITY:
 Please comment on any concerns regarding sexual issues:

PHYSICAL HEALTH:

Does the guest experience:
 Shortness of breath Headaches Joint inflammation Insomnia Dizziness
 Edema (tissue swelling) Nightmares Sleep apnea Over-fatigue
 Persistent cough Diarrhea Constipation Anuria (kidney dysfunction)

How are these problems normally treated?

Do any of these problems need to be monitored by our health care staff?

Does guest exaggerate physical or other problems to seek attention? Yes No
 If yes, please explain.

Menstruation: Normal Pain/discomfort
 (If cycle is due to begin while at camp, please provide supplies and inform support staff)

Recent major illness: When: Did guest visit the doctor? Yes No

Has the guest been hospitalized in the last year? Yes No
 Please indicate reason(s) for hospitalization:

Have there been any significant medical or physical changes in the last year? Yes No
 Please describe:

Are all vaccinations and inoculations up to date? Yes No
 If no, please ensure that they are before camp begins.

Does the guest have conditions requiring medical treatment while on vacation? Yes No
 Please explain:

Are there any activities that should be avoided: Yes No
 If so, what and why?

Use a separate page for further information that may be helpful in providing proper care, assistance and support to guest.

I confirm that all information provided is accurate and complete to the best of my knowledge. The guest is non-violent and able to vacation in a group setting.

Date: _____ Signature: _____
 Printed Name: _____

Checks should be made payable to Christian Horizons. Deposits are non-refundable unless the registration is not accepted or there are no openings available, in which case the full deposit will be returned.
 If you wish to cancel your vacation, you must notify Christian Horizons (failing to send the balance of your fees does not constitute cancellation). Written cancellation of at least 60 days prior to camp commencement or cancellation due to illness, with a supporting medical certificate, will receive a full refund, minus deposit.

Send completed application to: CHRISTIAN HORIZONS
 1115 3rd St Apt A
 Muskegon MI 49441
Call: 616-956-7063 **E-mail: infousa@christian-horizons.org** **www.christianhorizonsusa.org**

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