EXCEPTIONAL ADVENTURES

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2017
Guest Information Sheet

Guest Name: _____ Guest #: _____

Please complete and return this form two (2) weeks before your scheduled trip / event. Failure to provide the requested information may result in your removal from that event

GENERAL INFORMATION:

Today's Date: _____

LEGAL NAME (AS IT APPEARS ON ID / PASSPORT):

Last Name: _____ First Name: _____ Middle Name: _____

Nickname (What does the traveler like to be called?) _____ Male: ☐ Female: ☐

Birthdate: _____ Social Security #: _____

Guest Address 1: _____ Phone: _____

(Address line 2): _____ Phone: _____

City: _____ State: _____ Zipcode: _____ E-mail: _____

Alternate Address Where Trip/Event Info Is Sent (If Different From Above)

Other Address: _____ Phone: _____

City: _____ State: _____ Zipcode: _____ E-mail: _____

SUPPORTS COORDINATION INFORMATION:

(SCO): _____ Supports Coordinator: _____ Phone: _____

AGENCY INFORMATION (IF APPLICABLE):

Agency Name (*Where do you reside?*): _____

DOES THE GUEST HAVE:

Walking Problems:

Walks on All Surfaces:	Yes: ☐	No: ☐	Stands To Transfer:	Yes: ☐	No: ☐
Has Difficulty on Stairs:	Yes: ☐	No: ☐	Transfers In/Out of Wheelchair:	Yes: ☐	No: ☐
Uses a Wheelchair:	Yes: ☐	No: ☐	*If "No", specify assistance needed*:		
Uses a Walker or Cane:	Yes: ☐	No: ☐	_____		

Respiratory Problems:

Has Asthma: Yes: ☐ No: ☐ C-PAP: Yes: ☐ No: ☐
Has COPD: Yes: ☐ No: ☐ Nebulizer: Yes: ☐ No: ☐
On Oxygen: Yes: ☐ No: ☐ Other: _____

Heart Problems:

High Blood Pressure: Yes: ☐ No: ☐
Has a Pacemaker: Yes: ☐ No: ☐
Has had a Heart Attack: Yes: ☐ No: ☐ If "Yes", Provide Date: _____
Has had a Stroke: Yes: ☐ No: ☐ If "Yes", Provide Date: _____
On Coumadin? Yes: ☐ No: ☐

Epilleptic / Seizure Activity:

Has History of Seizures: Yes: ☐ No: ☐
Description of the seizures: _____
How long do they typically last? _____
Date of Last Seizure: _____
Length of Last seizure: _____

Has VNS Yes: ☐ No: ☐
(Vagus Nerve Stimulation)
Special Instructions: _____

Diabetes:

Has Diabetes Yes: ☐ No: ☐ *If "Yes", Requires* Oral Medication? Yes: ☐ No: ☐
Insulin Injection? Yes: ☐ No: ☐
Special Instructions: _____
Special Diet: _____

Special Dietary Needs:

Sugar Free: Yes: ☐ No: ☐ Low Cholesterol / Low Fat: Yes: ☐ No: ☐
Vegetarian Diet: Yes: ☐ No: ☐ Textured Food: Yes: ☐ No: ☐
Low Sodium: Yes: ☐ No: ☐ *If "Yes", specify:* _____
Lactose Free: Yes: ☐ No: ☐ Thickened Liquids: Yes: ☐ No: ☐
Gluten Free: Yes: ☐ No: ☐ *If "Yes", specify:* _____
Other: _____

Vision / Speech / Hearing Problems:

How does the person communicate? _____
Wears Eyeglasses: Yes: ☐ No: ☐ Has Dentures: Yes: ☐ No: ☐
Wears Contact Lenses: Yes: ☐ No: ☐ Hearing Aid(s): Yes: ☐ No: ☐
Hearing Impaired / Loss: Yes: ☐ No: ☐ Sign Language: Yes: ☐ No: ☐

Communicable Disease:

Hepatitis Yes: ☐ No: ☐ Tuberculosis: Yes: ☐ No: ☐
MRSA Yes: ☐ No: ☐ Other: _____

Allergies:

Seasonal: Yes: ☐ No: ☐ Describe: _____
To Medications: Yes: ☐ No: ☐ Describe: _____
Latex Allergies: Yes: ☐ No: ☐ Describe: _____
Food Allergies: Yes: ☐ No: ☐ Describe: _____
Other: _____
Do you have an Epi-Pen? Yes: ☐ No: ☐
If "Yes", include Special Instructions: _____

Behavioral Challenges: **** MUST BE FILLED OUT ****

None: Yes: ☐ No: ☐ Sexual: Yes: ☐ No: ☐
Wanders: Yes: ☐ No: ☐ Aggressive: Yes: ☐ No: ☐
Taking Things/Shoplifting: Yes: ☐ No: ☐
Other: _____
Suggested Means of Addressing Behavioral Challenges:

ATTENDING TOURS / EVENTS:

General Info:

I have my own One-on-One Staff: Yes: ☐ No: ☐
I am Independent with Medications: Yes: ☐ No: ☐ My T-Shirt Size: _____
I like Amusement Park Rides: Yes: ☐ No: ☐
Fast Rides: *Yes:* ☐ *No:* ☐
Slow Rides: *Yes:* ☐ *No:* ☐

I like Going in Swimming Pools: Yes: ☐ No: ☐
Can swim: *Yes:* ☐ *No:* ☐
Needs assistance in pool: *Yes:* ☐ *No:* ☐

I get the Bus at: ☐ BUTLER ☐ IRWIN ☐ GREENTREE

Identification / Passport:

I have valid state issued ID: Yes: ☐ No: ☐ ***Required for all Trips / Events**
I have a valid Passport: Yes: ☐ No: ☐ ***Required for travel outside of the U.S.**

Emergency / After-Hours Contact(s):

Person to notify in an emergency: (These contacts / numbers must be available after normal business hours! Examples of acceptable Emergency Contacts are cell phone numbers, on call staff numbers and family members.) Must list at least three (3) numbers!

	First Name	Last Name	Phone:	Cell:
Contact #1:				
Contact #2:				
Contact #3:				

Medications / Special Medical Needs:

Please List all Medications and Time of Dosage: Please note that this form is used throughout the current calendar year. You are responsible to notify us of any medication changes. (Please attach Home visit sheets, MARS or notes listing time of dosage!) List all medication even if not used on every trip. *Guests requiring insulin injections must contact our office prior to the tour to confirm arrangements. *Guests bringing Oxygen on trips must contact our office prior to the tour to confirm arrangements.

Person to call if we have questions about medications: Name: _____

Phone: _____

Name of Medication:	**Dosage:**	**Time(s):**

Special Instructions – *Include information on any special equipment or medical needs the guest may have during a trip or event* ("*On Oxygen", "Has Colostomy Bag", "Take pills with applesauce", etc*):

Consent to Photograph:

Exceptional Adventures would very much appreciate permission to photograph participants on trips/events and to use these photographs in its promotional material.

I give permission to photograph the participant named above in activities on trips/events operated by "Exceptional Adventures." Yes: ☐ No: ☐

If "Yes", pick one --»

_____ Permission to Photograph --- no names

_____ Permission to Photograph --- use of first name

_____ Permission to Photograph --- use of first and last name

Name of person filling out this form: _____

Title / Relationship to Guest: _____ E-mail: _____

Phone #: _____

SIGNATURES:

_____ _____

Guest Signature Date

_____ _____

Appointed Guardian or Person Assisting with this Form Date