2020 Camp and Respite Application
Over the course of the next several pages you will be asked a variety of questions to help our staff learn more about you or the person you represent. True Friends partners with caregivers to provide a successful experience for all parties involved. Please be open and honest with the information you provide.

We collect a lot of detailed information to serve you or the person you represent, below are a handful of reminders:

1. All questions in the application must be answered before the application is submitted. You will not be registered for a session until a completed application has been received.

2. As a Home and Community Based Service, and operating under a 245D license, we must provide you with our policies and procedures. These policies and procedures can be found by visiting www.truefriends.org/policies-procedures. Paper copies will be available at check-in.

3. Please allow up to two hours to complete the application. Please work through the application from beginning to end to help prevent questions from being missed. The application is speaking directly to the participant, if you are not the participant, please provide the information as if you were the participant. Throughout the application you may be asked to provide additional questionnaires (see list to the right). Please send copies of these documents with your application, they can be found at the end of the application.

4. Deposits are required to attend a True Friends Camp session. Please see the camp catalog to identify the deposit amount required for your session(s). Applications will not be confirmed or processed until a deposit has been received. Deposits will be applied toward the total cost of camp. Deposits are not required for individuals using Waivered Service Funds, County Funds or Adoption Assistance Funds to pay for their sessions.

5. **New in 2020 – Individuals using Waivered Funds**
Your most recent Coordinated Service Support Plan (CSSP)/Consumer Support Plan (CSP) is required for individuals using Waivered Service Funds (BI, CAC, CADI, DD, CDCS, EW). The CSSP/CSP must be sent with your application. Applications will not be confirmed or processed until a CSSP/CSP has been received. Please call your Case Manager to obtain a copy or for additional questions.

6. If you wish to make any session, medication, or behavior changes AFTER you submit your application, please call or email with those changes. Changes made in your account following application submission, will go unnoticed, unless a phone call or email is received.

If you have any questions please contact our Customer Relations team at registration@truefriends.org or 952.852.0101. The team is available Monday – Friday, 8 a.m. – 4:30 p.m. For tips on how to register visit www.truefriends.org/register-pay.

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**Documents Needed at the time of Registration**
Please send the following documents with your application. Your application will not be processed until all of the required documents are received:

**Required Documents**

- ____ Annual Physical
- ____ Medication List from health care professional
- ____ Medication Administration Record
- ____ Deposit (if applicable)
- ____ CSSP/CSP- See #5. (if applicable)

**If Applicable Documents**

Health care questionnaires
- ____ Catheter/Colostomy
- ____ Diabetes
- ____ Feeding Tube
- ____ Orthopedic
- ____ Seizure Action Plan
- ____ Suctioning/Trach.

All health care questionnaires can be found at the back of this application.
Camp and Respite Application

General Information – Tell Us About Yourself

Person filling out the application: ___________________________ Relationship to Participant: ___________________________

Name: 

<table>
<thead>
<tr>
<th>Last</th>
<th>Legal First Name</th>
<th>Middle Initial</th>
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Address:

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<tr>
<th>Street (include Apt. #, if applicable)</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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Telephone: (_____) __________ County of Birth: __________ County of Residence: __________

Email: ____________________________ Age: _______ Date of Birth: ____________ Male____ Female____

Current Height: _______ Current Weight: _______ Right handed: ___ Left handed: ___ Are you your own guardian?: ___ Yes ___ No

Attend school: ____Yes ____No   If yes, where: ___________________________________________________________________________

Employed: ___Yes ___ No   Where: _______________________________

Religious preference: ____________________________ Race: ___ White ___ African-Am ___ Native-Am ___ Asian ___ Hispanic ___ Multi-racial ___ Other

If other, please specify: __________________________________________________________

Living Situation: Res. Group Home/Apt. ___ Nursing Home___ Private Home(with parent/guardian)___ Lives Independently___ Foster Home___

Residential Group Home/Apt. Name: __________________________________________________________________________

Corporate Owner Name: ____________________________ Facility Address: ____________________________

Facility Contact Person: ____________________________ Facility Telephone: (_____) __________

Facility Email: ____________________________ Facility Cell Phone: (_____) __________

Facility Nurse: ____________________________ Nurse Phone: (_____) _______________________

Supervision or Support Need is: ___ High (1:1)   ___ Medium (1:3)   ___ Low (1:5)

Are you able to have unsupervised time by yourself? Please indicate for how long each day. (Unsupervised time is time that you can be alone without staff where you can travel where you like onsite, and then check in with staff. This does NOT mean that this will happen every day only that it is allowed.) Please note: waterfront and pool locations are supervised at all times, when in use.

___None    ___15-30 min ___30 min-1 hr. ___1-2 hrs. ___Rest time only    ___I am able to direct my own wants and needs

Have there been any changes to medication, behavior, or personal concerns since you last attended?   ___ Yes ___No    ___ N/A

If yes, please explain: _______________________________________________________________________________________________

__________________________________________________________________________________________________________________

Will you be bringing a service animal? ___ Yes ___ No   If yes, please see our Service Animal Policy at truefriends.org/policies-procedures.

Contact Information

#1 Parent/Legal Guardian name: ____________________________ Phone number (_____) ____________ Is parent also the guardian?: ___ Yes ___ No

Address:

<table>
<thead>
<tr>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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<tbody>
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</table>

Place of employment: ____________________________ Work number: (_____) ____________

Name of company  Position/title

#2 Parent/Legal Guardian name: ____________________________ Phone number: (_____) ____________ Is parent also the guardian?: ___ Yes ___ No

Address: ____________________________ Place of employment: ____________________________ Work number: (_____) ____________

Questions? Call 952.852.0101 or registration@truefriends.org.
Participant Name: __________________________________________________________ Date of Birth: __________________________

Social Worker/Case Manager name: ____________________________________________________________

County: ___________________________ Phone number: (____) __________________________ Cell phone: (____) __________________________ Email: __________________________

Emergency Contacts: Please list two additional contacts to be reached in the event that the first two contacts cannot be reached:

#1 Emergency Contact name: __________________________ Relationship to you: __________________________

Phone #1: (____) __________________________ Phone #2: (____) __________________________ Phone #3: (____) __________________________

#2 Emergency Contact name: __________________________ Relationship to you: __________________________

Phone #1: (____) __________________________ Phone #2: (____) __________________________ Phone #3: (____) __________________________

All correspondence regarding the registration of this applicant will be sent to the individual chosen below. Please note True Friends requires a variety of materials to complete registration. Please see the camp/respite catalog for more information or visit www.truefriends.org.

Please choose one:

___ Participant Email ___ #1 Parent/Legal Guardian Email ___ #2 Parent/Legal Guardian Email ___ Social Worker/Case Manager Email

Healthcare Information

Primary Doctor: __________________________ Name __________________________ Address __________________________ City/State/Zip (____) ______ Phone (____) ______

Mental Health Provider: __________________________ Name __________________________ Address __________________________ City/State/Zip (____) ______ Phone (____) ______

Dental Provider: __________________________ Name __________________________ Address __________________________ City/State/Zip (____) ______ Phone (____) ______

Primary Health Care Insurance Provider Name: __________________________

Policy #: __________________________ Policy holder’s name: __________________________

Diagnosis/Disability/Condition

What is your Primary Diagnosis? __________________________ Secondary Diagnosis: __________________________

Please check any additional diagnosis/disability/condition that apply. Conditions in *BOLD PRINT require an additional questionnaire, which are available for download at www.truefriends.org/forms. The questionnaires must be included when you submit your application and are attached at the end of the application.

___ No Diagnosis/Disability/Condition ___ Alzheimer’s or Dementia (Beginning Stage) ___ Amputee

___ Anxiety ___ Arthritis ___ Asthma

___ Attention Deficit Disorder ___ Attention Deficit Hyperactive Disorder ___ Blood Disorder: __________________________

___ Autism ___ Bipolar Disorder ___ Cerebral Palsy

___ Brain Injury ___ *CATHETER ___ *DIABETES – Type 2 ___ Down Syndrome ___ *DIABETES – Type 1 ___ *FEEDING TUBE

___ Developmental-Cognitive or Intellectual Disability ___ Depression ___ *EPILEPSY/SEIZURES. If yes, please provide protocols.

___ Fetal Alcohol Spectrum Disorder ___ Heart Problems, explain: __________________________

___ MRSA: ___ Active ___ Inactive ___ Muscular Dystrophy (MD)

___ Multiple Sclerosis (MS) ___ Obsessive-Compulsive Disorder ___ Oppositional Defiant Disorder

___ *ORTHOPEDIC APPLIANCES ___ Pica ___ Post Traumatic Stress Disorder

___ Paraplegia ___ Parkinson’s ___ Pervasive Developmental Disorder

___ Prader-Willi Syndrome ___ Quadriplegia ___ Reactive Attachment Disorder

___ Respiratory ___ Rett Syndrome ___

___ Spina Bifida ___ Sensory Processing Disorder, explain: __________________________

___ Tourette Syndrome ___ *TRACHEOSTOMY ___ Williams Syndrome

___ Blind ___ Vision impaired, no correction ___ Wears glasses

___ Deaf ___ Hearing impaired, no correction ___ Wears hearing aid x 1 ___ Wears hearing aid x 2

___ Left ear ___ Right ear ___

___ Uses Sign Language ___ Needs a staff proficient in sign language ___ Other disability/diagnosis/condition, please explain: __________________________

____________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________

Questions? Call 952.852.0101 or registration@truefriends.org.
Allergies
Do you have a food allergy? ___ Yes ___ No If yes, please explain the food allergy and specify your reaction to the allergy: ____________________________________________________________________________________________________________________________________________________________

Do you have a medication allergy? ___ Yes ___ No If yes, please explain the medication allergy and specify your reaction to the medication allergy: ____________________________________________________________________________________________________________________________________________________________

Do you have an environmental allergy? ___ Yes ___ No If yes, please explain the environmental allergy and specify your reaction to the environmental allergy: ____________________________________________________________________________________________________________________________________________________________

All medications must be PRE-SET. All medications must include a current medication list from a health care professional and a medication assessment form to avoid service interruptions. This does not need to include non-prescription medications. Please bring any necessary equipment and instructions needed to provide medications to check-in.

How many regularly scheduled medications will you take at camp? (please provide a number): ___

Medications Taken While at True Friends

In treatment for any condition, is there an order for Medical Cannabis or Synthetic THC? ___ Yes ___ No
*Due to federal regulations neither, medical cannabis or synthetic THC is allowed on True Friends property.
Do you carry an Epi-pen?: ___ Yes ___ No (if yes, please also list this with your medications)
Are you bringing a rescue medication?: ___ Yes ___ No If yes, what rescue medication are you bringing?

All medications will be reviewed at check-in. Standing Orders of over-the-counter medications will be reviewed at check-in. For our current list, please visit www.truefriends.org/forms.

Social Interactions & Behaviors

Ever been away from home before? ___ Yes ___ No

Is home sickness anticipated? ___ Yes ___ No

Any fears such as animals, thunderstorms, night time, heights, large crowds, water, etc.? ___ Yes ___ No Explain: ____________________________________________________________________________

How do you take your medications? Please check all that apply: ___ Swallows whole with water ___ Whole in applesauce or pudding ___ Crush meds in applesauce or pudding ___ Uses oral syringe (please send) ___ Uses medicine spoon (please send) ___ Other, explain: ____________________________________________________________________________

In treatment for any condition, is there an order for Medical Cannabis or Synthetic THC? ___ Yes ___ No
*Due to federal regulations neither, medical cannabis or synthetic THC is allowed on True Friends property.
Do you carry an Epi-pen?: ___ Yes ___ No (if yes, please also list this with your medications)
Are you bringing a rescue medication?: ___ Yes ___ No If yes, what rescue medication are you bringing?

All medications will be reviewed at check-in. Standing Orders of over-the-counter medications will be reviewed at check-in. For our current list, please visit www.truefriends.org/forms.

Does the participant display any behavioral issues? ___ Yes ___ No If yes, please check all behaviors below:

___ Self-injurious behaviors ___ Temper tantrums ___ Takes clothes off

___ Uses inappropriate language ___ Inappropriate sexual behaviors ___ History of stealing

___ Physically aggressive toward others: ___ Biting ___ Slapping ___ Punching ___ Kicking ___ Choking ___ Spitting ___ Rectal digging

___ Physically aggressive toward property ___ Stubbornness ___ Food related (stealing/eating inedible objects)

___ Elopes/runs away unintentionally ___ Elopes/runs away intentionally ___ Fecal smearing ___ Displays unusual behavior toward female staff

___ Displays unusual behavior toward male staff ___ Exaggerates/fabricates information ___ Suicidal tendencies/thoughts

Other, describe: ____________________________________________________________________________

What will or may trigger the above behaviors? Please check all triggers below:

___ Happens “out of the blue” ___ Not getting what he/she wants ___ Unwanted peer interaction

___ Unwanted authoritative interaction ___ Attention-seeking ___ Environmental factors (noise, temperature, sensory over/under stimulation). Please explain:

When do you see most behaviors occurring? ___ Hungry ___ Uncomfortable ___ Hurt ___ Bored ___ Dysregulated ___ Unknown

Other: __________________________

How often do these behaviors occur? ___ Seldom (1x/month) ___ Often (1x/week) ___ Frequently (More than 1x/week) ___ Daily

What behavioral indicators might exist that show the person is in distress, before a behavior exists?

Please explain what the behavior typically looks like, what redirection is done, and what the typical response is to redirection: ____________________________________________________________________________

What are effective tools for de-escalation of the behavior?: ____________________________________________________________________________

Do you anticipate any concerns with this participant going out into the community? ___ Yes ___ No If yes, please explain: ____________________________________________________________________________

Does the participant ever require physical intervention? ___ Yes ___ No If yes, please explain type of intervention, purpose, and frequency: ____________________________________________________________________________

Is there any physical intervention that is contraindicated medically? ___ Yes ___ No If yes, please explain: ____________________________________________________________________________

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Questions? Call 952.852.0101 or registration@truefriends.org.
Activities of Daily Living Information – What Does Your Day Look Like?

Special Appliances/Ambulation – Please provide needed equipment and complete the Orthopedic Appliance Questionnaire.

Wheelchair? ___ Yes ___ No  If yes, please explain: ___ Manual ___ Electric ___ Stroller ___ Long distances only
 Assistance in walking? ___ Yes ___ No  Support from another person ___ Cane ___ Walker ___ Slow walker ___ May fall easily
 What are the scheduled times out of the wheelchair?: ______________________________________________________________________________________________________________________
 Assistance in transferring? ___ Yes ___ No
 What type of transfer is used?: ____________________________________________________________________________________________  Mechanical lift: ___ Yes ___ No
 Require range of motion exercises? ___ Yes ___ No  If yes, please attach a copy of exercises.
 Do you wear/use? ___ Orthotics circle: left or right ___ Prosthesis circle: left or right ___ Braces/night braces
 Further Instructions: ____________________________________________________________________________________________________

Wheelchair? ___ Yes ___ No  If yes, please explain: ___ Manual ___ Electric ___ Stroller ___ Long distances only
 Assistance in walking? ___ Yes ___ No  Support from another person ___ Cane ___ Walker ___ Slow walker ___ May fall easily
 What are the scheduled times out of the wheelchair?: ______________________________________________________________________________________________________________________
 Assistance in transferring? ___ Yes ___ No
 What type of transfer is used?: ____________________________________________________________________________________________  Mechanical lift: ___ Yes ___ No
 Require range of motion exercises? ___ Yes ___ No  If yes, please attach a copy of exercises.
 Do you wear/use? ___ Orthotics circle: left or right ___ Prosthesis circle: left or right ___ Braces/night braces
 Further Instructions: ____________________________________________________________________________________________________

Sleeping – Please note: True Friends does not provide overnight awake staff. Staff only assist with typical needs at night.

Sleeps through the night? ___ Yes ___ No ___ Not Applicable
 If no, please explain sleeping patterns/supervision needs: ____________________________________________________________________________________________
 Will you leave the cabin at night? ___ Yes ___ No
 Bed time rituals? ___ Yes ___ No  If yes, please explain: ____________________________________________________________________________________________
 If you wake at night, what helps to get you back to sleep?: ____________________________________________________________________________________________
 Are you able to sleep in lower bunk without bed rails? ___ Yes ___ No  Are you able to sleep in top bunk?: ___ Yes ___ No
 What time do you wake up in the morning, typically: ___________  What time do you go to bed, typically: _____________

Eating – Please provide needed utensils and supplies.

Assistance level: ___ Independent ___ Verbal reminders ___ Cut food (eats independently) ___ Some assistance ___ Total assistance
 Typical appetite is: ___ Large ___ Medium ___ Small
 Special diet? ___ None ___ Diabetic ___ Lactose intolerant ___ Gluten free ___ Low Sugar ___ Vegan ___ Vegetarian ___ Low calorie ___ Pureed ___ Chopped ___ Low sodium ___ Low cholesterol ___ Nectar thick liquids ___ Honey thick liquids ___ Other restrictions?: ______________________________________________________________________________
 Difficulty with: ___ Swallowing ___ Chewing ___ Drinking liquids
 Do you require: ___ Special utensils (bring) ___ Chopped food ___ Dietary supplement (bring) ___ Bite size pieces ___ Straw ___ Feeding tube
 Further instructions/information about eating or diet: __________________________________________________________________________________________________

Bathroom Use

Assistance in bathroom? ___ Independent ___ Some assistance ___ Total assistance ___ Will use either shower or bath ___ Will only shower ___ Will only bathe
 Requires assistance with: ___Washing body ___ Brushing teeth ___ Hair care ___ Shaving ___ Menstrual care ___ Bathing ___ Showering ___ Adjusting water temperature
 Denture use?: ___ Yes ___ No  Removes dentures at night?: ___ Yes ___ No  Orthodontics?: ___ Yes ___ No  Retainers?: ___ Yes ___ No
 Please explain in detail the type of assistance needed in each area: __________________________________________________________________________________________________

Use of incontinent product?: ___ Yes ___ No  If yes, please be sure to supply plenty of products, and extras, to accommodate your stay.
 AM product: ___  PM product: ___
 Bathroom schedule?: ___ Yes ___ No  Please explain: ____________________________________________________________________________________________
 Designated overnight times: ___ 11 p.m. ___ 3 a.m. ___ 7 a.m. ___ Other: ____________________________________________________________________________________________
 Do you use: ___ Urinal ___ Bedpan ___ Commode ___ Intermittent catheter  Please complete Catheter and Colostomy Questionnaire.
 Schedule: ____________________________________________________________________________________________

Do you have a Bowel Program?: ___ Yes ___ No  *Bowel program medications must be included on the Medication List for Medication Administration at True Friends.
 __ I have a different bowel program (please explain): ____________________________________________________________________________________________

Dressing/Clothing & Personal Items

Assistance with dressing: ___ Independent ___ Some assistance ___ Total assistance
 Help with: ___ Buttons ___ Shoes ___ Shoe laces ___ Socks ___ Fasteners ___ Zippers ___ Shirt ___ Undergarments ___ Pants
 Assistance with: ___ Reminders to wear clean clothes ___ Separating clean and dirty/soiled clothes
 Further instructions: __________________________________________________________________________________________________

Are you able to care for and keep track of your own belongings?: ___ Yes ___ No  PLEASE LABEL ALL ITEMS BROUGHT TO CAMP.
### Communication

<table>
<thead>
<tr>
<th>Ability</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Able to communicate wants/needs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbal-speaks clearly</td>
<td></td>
<td></td>
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<tr>
<td>Verbal-difficult to understand</td>
<td></td>
<td></td>
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<tr>
<td>Uses a communication device</td>
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<tr>
<td>Sign Language</td>
<td></td>
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<tr>
<td>Non-verbal/gestures</td>
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<td></td>
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<tr>
<td>Uses Picture Exchange Communication System (PECS)</td>
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</table>

**Understands/responds to questions?**

- [ ] Yes
- [ ] No

**Has difficulty understanding the communication of others?**

- [ ] Yes
- [ ] No

**Has difficulty expressing thoughts?**

- [ ] Yes
- [ ] No

**Able to read?**

- [ ] Yes
- [ ] No

**Able to write?**

- [ ] Yes
- [ ] No

**Can you indicate pain?**

- [ ] Yes
- [ ] No

**Do you need ear plugs when in the water?**

- [ ] Yes
- [ ] No

**Do you need a Personal Flotation Device when swimming or wading?**

- [ ] Yes
- [ ] No

**Further instructions:**

_________________________________________________________________________________________________________________

_________________________________________________________________________________________________________________

_________________________________________________________________________________________________________________

### Activity Interests & Abilities

#### Activity Interests & Abilities*

*Activities are seasonal and may not be available for each program.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Boating</td>
<td></td>
<td></td>
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<tr>
<td>Tubing</td>
<td></td>
<td></td>
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<tr>
<td>Water skiing</td>
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<tr>
<td>Canoeing</td>
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<tr>
<td>Kayaking</td>
<td></td>
<td></td>
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<tr>
<td>Tent Camp</td>
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<td></td>
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<tr>
<td>Ride a bike</td>
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<tr>
<td>Zip Lining</td>
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<tr>
<td>Swimming</td>
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</table>

**Swimming ability level?**

- [ ] Does not swim
- [ ] Prefers wading
- [ ] Beginner
- [ ] Intermediate
- [ ] Experienced

**If you do not enjoy swimming, do you want to be at the lake or pool during swim time?**

- [ ] Yes
- [ ] No

**If not a swimmer, do you enjoy splashing your feet in the water?**

- [ ] Yes
- [ ] No

**Do you need a Personal Flotation Device when swimming?**

- [ ] Yes
- [ ] No

**Will you swim in a lake?**

- [ ] Yes
- [ ] No

**Are there other activities you want to try?**

_________________________________________________________________________________________________________________

**I really enjoy:**

_________________________________________________________________________________________________________________

_________________________________________________________________________________________________________________

**Have you ever attended True Friends services?**

- [ ] Yes
- [ ] No

**Check location(s) attended:**

- [ ] Camp Friendship, Annandale
- [ ] Camp Eden Wood, Eden Prairie
- [ ] Camp Courage, Maple Lake
- [ ] Camp Courage North, Lake George

**How did you hear about True Friends?**

- [ ] Social worker
- [ ] Teacher
- [ ] Friend/family
- [ ] ARC
- [ ] DSAM
- [ ] AUSM
- [ ] Conference/Event
- [ ] Other: ________________________

**Tell Us About Your History With True Friends**

**Session Request & Transportation**

**Please identify the session(s) number you would like to attend:**

1st choice: __________________________  2nd choice: __________________________

3rd choice: __________________________  4th choice: __________________________

**Do you want to attend each session listed above, if possible?**

- [ ] Yes
- [ ] No

If no, we will confirm you for the first available session; in the preferred order listed above.

**Do you want to attend more session(s) than what is listed above?**

- [ ] Yes
- [ ] No

If yes, please list each additional session you wish to attend:

_________________________________________________________________________________________________________________

_________________________________________________________________________________________________________________

_________________________________________________________________________________________________________________

**Do you have a cabin mate request?**

Name: ____________________________ (We will do our best to respect your request, but cannot guarantee it.)
Transportation Options
Transportation is only available during select weeks of summer camp. Please see the camp catalog for sessions that have transportation availability (noted with a “T” next to the session number). Transportation is not available for winter camp or respite.
Do you need transportation to a True Friends program?  ___Yes  ___No

Release & Authorization Information

Admission Authorization
I hereby give permission for the applicant to participate in True Friends (TF) sponsored and supervised programs. I certify that the information on the application is true, accurate and complete. True Friends emphasizes safety first; however, participation in True Friends programs has inherent risks that may result in injury. I acknowledge and accept this fact and agree to hold harmless True Friends, its employees, and agents.

___  Yes   _____________________________________________________________________________________________
Signature    Date

Release of Information Authorization
In order to provide the best services, True Friends may need to obtain information from you or share information with other individuals, programs, or providers. Without your permission to release information True Friends may not be able to provide the services needed or True Friends’ assistance may be hindered. The below information meets the requirements of the federal Data Privacy and HIPPA regulations.

I (representing myself or applicant's legal guardian) request and authorize True Friends to receive and disclose information needed to provide services to the applicant from the following parties:

• Applicant
• Case manager and other county personnel
• Residential providers
• Applicant's legal guardian
• Department of Human Services
• Medical personnel including primary doctor, psychologist, psychiatrist

I know that state and federal laws protect my/applicant's records. I understand:

• Why I am being asked to release this information  • I do not have to consent to the release of information.
• If I do not consent the information will not be released unless the law otherwise allows it.
• I may stop this consent with written notice at any time but this written retraction will not affect information True Friends had already released.
• The person or agency receiving my information may be able to pass it on to others.
• If my information is passed on to others by True Friends, it will no longer be protected by this authorization.
• This consent will end one year from the signed date.

__________________________________________________________________________________________________________________
Signature    Date

Policy Receipt and Signature Information
I have been informed of and provided copies of the following policies and procedures affecting a person’s rights under section 245D; visit www.truefriends.org/policies-procedures to learn more. Please call 952.852.0101 to have policies and procedures mailed directly to you.

• Grievance Policy   • Service Suspension   • Service Termination   • Emergency Use of Manual Restraint
• Data Privacy   • Maltreatment Reporting   • Service Recipient Rights

__________________________________________________________________________________________________________________
Signature    Date

Funds and Property Authorization
True Friends may assist you with the safekeeping of funds or other property. For a full description of program requirements and restrictions visit www.truefriends.org/policies-procedures.

___ I authorize the program to assist me in safekeeping of funds and property.

___ I do not authorize the program to assist me in safekeeping of funds and property.

__________________________________________________________________________________________________________________
Signature    Date
Medication Administration and Emergency Medical Authorization
Please review and sign to provide your understanding of the information below. To read the full policy visit www.truefriends.org/policies-procedures.

I authorize staff trained by the program to provide medication assistance, setup and/or medication administration (prescription medications, including psychotropic medications and injectable medications, and over-the-counter medications) or treatments to me ordered for me by a health care professional.

___ Yes, I agree.

___ No, I refuse*. *If you refuse, True Friends is unable to serve you. Your application will be returned, and registration will be cancelled.

I authorize the program to act in a medical emergency when the person or the person’s legal representative cannot be reached or is delayed in arriving.

___ Yes, I agree.

___ No, I refuse*. *If you refuse, True Friends is unable to serve you. Your application will be returned, and registration will be cancelled.

Person
Name

Legal Representative
Name
Signature
Date

Release and Authorization for Use of Photographs, Images, Video and/or Sound Recordings
I hereby grant True Friends and all of its subsidiaries, the irrevocable right and permission, throughout the world, in connection with the photograph(s), images, video or sound recordings that were taken of me by, or which I provided to, True Friends the following: the right to use and reuse, in any manner at all said photographs, images, video, and/or sound recordings in whole or in part, modified or altered, either by themselves or in conjunction with other photographs, images, video and/or sound recordings, in any medium or form of distribution, and for any purposes whatsoever including, without limitation, all promotional, marketing and advertising uses, and other trade purposes, as well as using my name in connection therewith, if True Friends so desires. This permission is granted in perpetuity.

I hereby forever release and discharge True Friends from any and all claims, actions and demands arising out of or in connection with the use of said photographs, images, video and/or sound recordings including, without limitation, any and all claims for invasion of privacy and libel. This release shall inure to the benefit of the assigns, licensees and legal representatives of True Friends.

Participants/Guardian on behalf of Participant: Please check your preferred option.

___ Yes. I agree to allow True Friends to use photograph(s), images, video, or sound recording as stated above.

___ No. I do NOT allow True Friends to use photograph(s), images, video, or sound recording as stated above.*

* Please note by stating no, the participant will NOT be featured in group, or activity photos during their stay. They will not be featured through the True Friends website, social media, or other communication mediums.

Signature
Date
**Participant Name:** _____________________________________________ **Date of Birth:** _____________________________________________

**Deposits, Fee Agreements, Cancellation Policy & Payment Information**

**Waivers, Adoption Assistance, or County Funds.**
I will be paying for services with Adoption Assistance funds? ___ Yes ___ No
I will be paying for services with County funds? ___ Yes ___ No

I will be paying for services with Waivered Service Funds? ___ Yes ___ No If yes, please check the waiver that is approved to bill:
___ EW ___ BI ___ CAC ___ CADI ___ DD ___ CDCS ___ Out-of-State Waiver ___ Other: ________________________________
If CDCS, who is your Financial Management Services? _____________________________________________________________________________
If using Out-of-State Waiver please list bill name and address: _____________________________________________________________________________

**If using MN Waivered Service Funds, a copy of your Coordinated Service & Support Plan (CSSP) is REQUIRED with your application.**

**Private Pay. To pay by credit card please call 952.852.0132, otherwise, please include a check with camper name in memo.**
I will be privately paying for services? ___ Yes ___ No
___ Full payment enclosed ___ Deposit enclosed ___ Bill me later ___ Bill me for monthly payments (minimum $100/month)
Fee will be paid by:

<table>
<thead>
<tr>
<th>Name of Payee</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

**Camp Deposits**
Deposits are required to attend a True Friends Camp session. Please see the camp catalog to identify the deposit amount required for your session(s). Applications will not be confirmed or processed until a deposit has been received. Deposits will be applied toward the total cost of camp. Deposits are not required for individuals using Waivered Service Funds, County or Adoption Assistance to pay for their sessions.

**Financial Assistance. Please note, Financial Assistance will only help pay for a portion of your stay with True Friends.**
___ I will apply for Financial Assistance – must complete Financial Assistance Form below in its entirety and submit with completed application. Financial assistance will not be awarded after the service has occurred and cannot be used for a deposit.

**Camp Cancellation Policy**
In the event of a cancellation, all fees paid will be refunded in full if notice is received in the True Friends office 30 days prior to the participant’s session. If less than 30 days notice is received, all fees paid but the deposit will be refunded. Waivered Service contracts will NOT pay cancellation fees. Participants/guardians will be privately billed, accordingly.

**Financial Assistance Application – If Applicable**
Please complete the application in its entirety to be considered for Financial Assistance. Due to limited Financial Assistance funds available, financial assistance requests must accompany the initial application. Funds are awarded on a first come, first served basis and will not be awarded after the service has occurred. Please note: if you are using waiver funds to pay for any portion of your fees, financial assistance is not available. Financial Assistance Awards will be included in your confirmation letter.

<table>
<thead>
<tr>
<th>Participant Name: _____________________________________________</th>
<th>Date of Birth: _____________________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Guardian Name (if applicable): _________________________</td>
<td>Spouse Name (if applicable): ________________________________</td>
</tr>
<tr>
<td>Total Number of Dependents (including yourself and spouse if applicable): ___</td>
<td>Total amount you are able to contribute toward the cost: $ ______</td>
</tr>
</tbody>
</table>

Provide a brief explanation of financial need (Please list extenuating circumstances on back of application or additional page if needed) Examples: Unemployed or Disability since last tax filing, Out of Pocket Medical, etc.

<table>
<thead>
<tr>
<th>Examples: Exhuating Circumstances (loss of income, significant out of pocket expense)</th>
<th>Wage Earner or Dependent Affected</th>
<th>Additional hardship since last tax filing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I/We verify that the above information is true and accurate. If requested, I/We agree to provide verification of income.

<table>
<thead>
<tr>
<th>Signature of camper/parent/guardian</th>
<th>Date</th>
</tr>
</thead>
</table>

2020 True Friends Application – Page 8
Questions? Call 952.852.0101 or registration@truefriends.org.
2020 Application – Health Care Questionnaires

On Page 2 of the 2020 application – under Health Care Information - we asked about your diagnosis/disability/condition. In the event you checked that you have one of the following diagnosis/disability/condition, we ask that you complete the accompanying questionnaire.

If you noted:

- Catheter - Please complete the Catheter/Colostomy Questionnaire
- Diabetes Type 1 or Diabetes Type 2 – Please complete the Diabetes Questionnaire
- Epilepsy/Seizures – Please complete the Seizure Action Plan Questionnaire
- Feeding Tube – Please complete the Feeding Tube Questionnaire
- Orthopedic Appliances – Please complete the Orthopedic Appliances Questionnaire
- Tracheostomy – Please complete the Suctioning/Trach. Questionnaire

You are not required to complete each questionnaire. Please only complete the questionnaire that refers to your diagnosis/disability/condition.

If you have any questions about the questionnaires please email registration@truefriends.org or 952.852.0101.
## Diabetes Management Plan & Participant Questionnaire

To avoid service interruptions, we require this form to be on file at the time of registration.

| Name: __________________________ | Date of Birth: ____________ | Dates Plan in Effect: ____________ |
| Emergency Contact: _______________ | Home #: ________________ | Cell#: ________________ |
| Treating Physician: _______________ | Phone #: ________________ |

### Assistance Level Needed:
- ___ Independent
- ___ Verbal reminders
- ___ Some assistance
- ___ Total assistance

### Blood Glucose Monitoring

- Target range for blood glucose is: ___ 80-180 ___ Other: ________
- How many glucose checks within 24 hours? ____________
- When to check blood glucose:
  - ___ Before breakfast
  - ___ Before lunch
  - ___ Before dinner
  - ___ Before snacks
- When to do extra blood glucose checks:
  - ___ Before exercise
  - ___ After exercise
  - ___ When showing signs of low blood glucose
  - ___ When showing signs of high blood glucose

### Insulin Plan

- What type of insulin regimen is used?: ___ Insulin pump ___ Multiple daily injections ___ Fixed insulin doses

*Please complete specific action plan below based on regimen used.

**Type of insulin used at home:**
- ___ Regular
- ___ Apidra
- ___ Humalog
- ___ Novolog
- ___ NPH
- ___ Lantus
- ___ Levemir
- ___ Mix
- ___ Other: ____________________________________________

---

**Plan A: Insulin Pump**

1. Always use the insulin pump bolus wizard: ___ Yes ___ No
   - If no, use insulin carbohydrate ratio and correction factor dosage on Plan B.
2. Blood glucose must be checked before participants eats and will:
   - ___ Be sent to the pump by the meter
   - ___ Need to be entered into the pump
3. The insulin pump will calculate the correction dose to be delivered before the meal/snack.
4. After the meal/snack, enter the total number of carbohydrates eaten at that meal/snack. The insulin pump will calculate the insulin dose for the meal.
5. Contact parent/guardian with any concerns.
   - For a list of definitions of terms used in this document, please see the reverse side.

*Providers will compare insulin: carbohydrate ratio and correction dosage under Plan B section for ALL pump users.

---

**Plan B: Multiple Daily Injections**

1. Participant will receive a fixed dose of:
   - ___ ____________ long-acting insulin at ____________am/pm
   - ___ Yes ___ No
   - If yes, give participant ________ unit(s) of ________ insulin at ________.
2. Follow blood glucose monitoring plan above.
3. Use ____________ insulin for meals and snacks. Insulin dose for food is:
   - ___ unit(s) for meals OR
   - ___ unit(s) for every ________ grams carbohydrate.
4. If blood glucose is above target, add correction dose to:
   - ___ Breakfast
   - ___ Lunch
   - ___ Snack
   - ___ Snack
   - ___ Other: ________________________

*Use the following correction factor: ________ or this scale:

| Unit(s) if BG is ________ to ________ | Unit(s) if BG is ________ to ________ |
| Unit(s) if BG is ________ to ________ | Unit(s) if BG is ________ to ________ |

**Plan C: Fixed Insulin Doses**

1. Child will receive a fixed dose of long acting insulin? ___ Yes ___ No
   - If yes, give participant ________ unit(s) of ________ insulin at ________.
2. Insulin correction dose at camp (_______ insulin)?
3. If blood glucose is above target, add correction dose to:
   - ___ Breakfast
   - ___ Snack
   - ___ Lunch
   - ___ Snack
   - ___ Other: ________________________

*Use the following correction factor ________ or the following scale:

| Unit(s) if BG is ________ to ________ | Unit(s) if BG is ________ to ________ |
| Unit(s) if BG is ________ to ________ | Unit(s) if BG is ________ to ________ |

**Only add correction dose if it has been three hours since the last insulin administration.**

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9.2019
Managing Very Low Blood Glucose

Hypoglycemia Plan for Blood Glucose less than 

__________________ mg/dl

2. Recheck blood glucose in 15 minutes.
3. If still below 70 mg/dl, offer 15 grams of fast acting carbohydrate, check again in 15 minutes.
4. When the participant’s blood glucose is over 70, provide 15g of carbohydrate as snack. Do not give insulin with this snack.
5. Contact parent/guardian any time blood glucose is less than ________ mg/dl while at True Friends.

Usual symptoms of hypoglycemia for you includes:

___ Shaky ___ Fast Heartbeat ___ Sweating
___ Anxious ___ Hungry ___ Headache
___ Dizzy ___ Blurry Vision ___ Fatigue
___ Irritable ___ Other: ______________________

1. If you suspect low blood glucose, check blood glucose!
2. If blood glucose is below ________, follow the plan above.
3. If the individual is unconscious, having a seizure or unable to swallow:
   - Give glucagon, Mix liquid and powder and draw up to the first hash mark on the syringe. Then inject into the thigh. Turn individual on side as vomiting may occur.
   - If glucagon is required, administer it promptly. Then call 911. After calling 911, contact the parents/guardian. If unable to reach parent, contact diabetes care provider.

Managing Very High Blood Glucose

Hyperglycemia Plan for Blood Glucose higher than 

__________________ mg/dl

Usual symptoms of hyperglycemia for the participant include:

___ Extreme thirst ___ Bathroom accidents
___ Hungry ___ Warm, dry, flushed skin
___ Tired or drowsy ___ Headache
___ Blurry vision ___ Vomiting***
___ Fruity breath ___ Rapid, shallow breathing
___ Abdominal pain ___ Unsteady walk

** If participant is vomiting, call parents immediately.

Treatment of hyperglycemia/very high blood glucose:

1. Check for ketones in the:
   ___ Urine ___ Blood
2. If ketones are moderate or large, contact parent. If unable to reach parent, contact diabetes care provider for additional instructions.
   Contact parents if ketones are trace or small: ___ Yes ___ No
3. Children with high blood glucose will require additional insulin if the last dose of insulin was given 3 or more hours earlier. Consult the insulin plan above for instructions. If still uncertain how to manage high blood glucose contact parent/guardian.
4. Provide sugar-free fluids as tolerated.
5. You may also:
   ___ Provide carbohydrate free snacks if hungry
   ___ Delay exercise

Diabetes Dictionary

Blood glucose – The main sugar found in the blood and the body’s main source of energy. Also called blood sugar. The blood glucose level is the amount of glucose in a given amount of blood. It is noted in milligrams in a deciliter, or mg/dl.

Bolus – An extra amount of insulin taken to lower the blood glucose or cover a meal or snack.

Bolus calculator – A feature of the insulin pump that uses input from a pump user to calculate the insulin dose. The user inputs the blood glucose and amount of carbohydrate to be consumed, and the pump calculates the dose that can be approved by the user.

Correction factor – The drop in blood glucose level, measured in milligrams per deciliter (mg/dl), caused by each unit of insulin taken. Also called insulin sensitivity factor.

Diabetic Ketoacidosis (DKA) – An emergency condition caused by a severe lack of insulin, that results in the breakdown of body fat for energy and an accumulation of ketones in the blood and urine. Signs of DKA are nausea and vomiting, stomach pain, fruity breath odor and rapid breathing. Untreated DKA can lead to coma or death.

Fixed dose regimen – Children with diabetes who use a fixed dose regimen take the same “fixed” doses of insulin at specific times each day. They may also take additional insulin to correct hyperglycemia.

Glucagon – A hormone produced in the pancreas that raises blood glucose. An injectable form of glucagon, available by prescription, is used to treat severe hypoglycemia or severely low blood glucose.

Hyperglycemia – Excessive blood glucose, greater than 240 mg/dL for children using insulin pump and greater than 300 mg/dL for children on insulin injections. If untreated, the patient is at risk for diabetic ketoacidosis (DKA).

Hypoglycemia – A condition that occurs when the blood glucose is lower than normal, usually less than 70 mg/dL. Signs include hunger, nervousness, shakiness, perspiration, dizziness or light-headedness, sleepiness and confusion. If left untreated, hypoglycemia may lead to unconsciousness.

Insulin – A hormone that helps the body use glucose for energy. The beta cells of the pancreas make insulin. When the body cannot make enough insulin, it is taken by injection or through use of insulin pump.

Insulin pump – An insulin-delivering device about the size of a deck of cards that can be worn on a belt or kept in a pocket. An insulin pump connects to narrow, flexible plastic tubing that ends with a needle inserted just under the skin. Pump users program the pump to give a steady trickle or constant (basal) amount of insulin continuously throughout the day. Then, users set the pump to release bolus doses of insulin at meals and at times when blood glucose is expected to be higher. This is based on programming done by the user.

Ketones – A chemical product when there is a shortage of insulin in the blood and the body breaks down body fat for energy. High levels of ketones can lead to diabetic ketoacidosis and coma.

Multiple Daily Injection Regimen – Multiple daily insulin regimens typically include a basal or long acting insulin given once per day. A short acting insulin is given by injection with meals and to correct hyperglycemia, or elevated blood glucose, multiple times each day.

Type 1 Diabetes – Occurs when the body’s immune system attacks the insulin-producing beta cells in the pancreas and destroys them. The pancreas then produces little or no insulin. Type 1 diabetes develops most often in young people but can appear in adults. It is one of the most common chronic disease diagnosed in childhood.
Seizure Action Plan & Participant Questionnaire

To avoid service interruptions, we require this form to be on file before attending any True Friends program.

Name: ___________________________ Date of Birth: __________________

Emergency Contact: _______________ Home #: ___________________ Cell#: _______________ Phone #: ___________________

Significant medical history: __________________________________________________________

When was your epilepsy diagnosed? ___

How often do you have seizures? _____________________________

Does illness or stress affect your seizure control? _____________________________

**Seizure Information**

<table>
<thead>
<tr>
<th>Seizure Type</th>
<th>Length</th>
<th>Frequency</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Seizure triggers or warning signs: ______________________________________________________________________________________

Post seizure behavior: ______________________________________________________________________________________

**Basic First Aid: Care & Comfort**

Please describe basic first aid procedures: __________________________________________________________

Does person need to leave the room/area after a seizure? ___ Yes ___ No

If yes, describe process for returning: __________________________________________________________

**Emergency Response**

A “seizure emergency” for this person is defined as: ______________________________________________________

Seizure Emergency Protocol: (Check all that apply and clarify below)

___ Call 911 for transport to: __________________________________________________________

___ Notify parent or emergency contact ______________________________________________________

___ Notify doctor __________________________________________________________

___ Administer emergency medications as indicated below __________________________________________

___ Other: __________________________________________________________

**Treatment Protocol (Include daily and emergency medications):**

<table>
<thead>
<tr>
<th>Emergency Medication</th>
<th>Dosage &amp; Time of Day Given</th>
<th>Route of Administration</th>
<th>Common Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Does person have a Vagus Nerve Stimulator (VNS)? ___ Yes ___ No If yes, explain protocols: ______________________________________________________________________

**Special considerations & Safety Precautions (Regarding activities, sports, travel, etc.)**

____________________________________________________________________________________

____________________________________________________________________________________

**Basic Seizure First Aid:**

- Stay calm and track time
- Keep person safe
- Do not restrain
- Do not put anything in mouth
- Do not put anything in mouth
- Keep airway open/watch breathing, color
- Turn individual on their side

**For tonic-clonic (grand mal) seizure:**

- Protect head
- Keep airway open/watch breathing, color
- Turn individual on their side

**A seizure is considered an emergency when:**

- A convulsive (tonic-clonic) seizure lasts longer than 5 minutes.
- There are repeated seizures without regaining consciousness
- It’s a first-time seizure
- The person is injured or has diabetes
- The person has breathing difficulties
- The seizure occurs in water

**Individual Signature: ___________________________ Date: __________________**

**Parent/Guardian Signature (if minor): ___________________________ Date: __________________**
Catheter and Colostomy Information Questionnaire

To avoid service interruptions, we require this form to be on file before attending any True Friends program. Please plan to spend time with direct care staff and nurses to demonstrate/assist with the first feeding/medication.

Name: _____________________________________________ Dates Attending: __________________________

Instructions For: (Check any that apply)    Catheter_____ Type (Indwelling, external Ex. Condom): ______________
Ostomy_____ Type (Ileostomy Colostomy): ______________

TO ENSURE CARE IS GIVEN IN THE MANNER IN WHICH THE PARTICIPANT IS ACCUSTOMED TO, INCLUDE COMPLETE INSTRUCTIONS FOR CLEANING, CHANGING, SKIN CARE and ANY OTHER INFORMATION:

BRING ALL SUPPLIES NEEDED FOR YOUR STAY INCLUDING ONE EXTRA DAY.

Does participant care for catheter/ostomy independently? _____ Needs assistance _____ Needs total help_____

How often does participant need to be cathed? ________________ Date originally inserted/placed ________________

When was the last time it was changed? ________________ 24-hour output ________________

Average amount of urine collected during cathing: ________________ Steps on cathing care and cath: (position, supplies, cleaning technique, normal vs. abnormal output, appearance)

1. _____________________________________________________________________________________________
2. _____________________________________________________________________________________________
3. _____________________________________________________________________________________________
4. _____________________________________________________________________________________________

Special tips or tricks to note?: __________________________________________________________________________

Leg bag support

What time(s) is bag to be emptied? ________________ How often is the bag changed? ________________ Is bag changed before or after shower. ________________

Steps on Ostomy care and Change: (position, supplies, cleaning technique)

1. _____________________________________________________________________________________________
2. _____________________________________________________________________________________________
3. _____________________________________________________________________________________________
4. _____________________________________________________________________________________________

Special tips or tricks to note?: __________________________________________________________________________

Additional information:

<table>
<thead>
<tr>
<th>Person Completing Form</th>
<th>Relationship To Participant</th>
<th>Phone</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>9.2019</td>
</tr>
</tbody>
</table>
Feeding Tube Questionnaire

To avoid service interruptions, we require this form to be on file before attending any True Friends program. Please plan to spend time with direct care staff and nurses to demonstrate/assist with the first feeding/medication at check-in.

Participant’s Name: ___________________________ Dates Attending: ________________________________

Feeding Tube Kind: □ G-tube □ GJ □ J □ Other: _______

Lumen size: (Fr) ___________ Length : ___________ Balloon Size: ___________

Position during feeding: ___________________________ Feeding/Formula Type: _________________________________

Directions if formula needs to be mixed: _____________________________________________________________

Bolus □ Yes □ No Continuous □ Yes □ No Pump rate _______/hr Brand of feeding pump: _______________________

Feeding Times:

<table>
<thead>
<tr>
<th>Amount (ml)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Water Flush after feedings (amount): ___________________________ Water flush after medications: ________________________________

Additional water allowed during the day: □ Yes □ No Amount given: ___________ How often: ______________

Needed Supplies: □ Formula □ Syringes □ Extensions □ Feeding bags □ Feeding pump □ Battery Charger □ Extra G-tube

□ Other: ______________ **Be sure to bring enough supplies, and site dressing supplies, to last for full duration of their stay plus 1 extra day)

If tube becomes dislodged, they will only be administered by a licensed health care professional. Please explain emergency protocols for dislodged tubes: ____________________________________________________________

________________________________________________________

________________________________________________________

Equipment will be cleaned with regular hand washing soap and water and hung to dry. If you require something different you will be required to bring your own supplies for cleaning.

Additional information:

________________________________________________________

________________________________________________________

Name of Person Completing Form: ___________________________ Relationship to Participant: ___________________________

Phone: ___________ Date: ___________
Orthopedic Appliances Questionnaire  
(Splints, Braces, Prostheses)

To avoid service interruptions, we require this form to be on file before attending any True Friends program. Please plan to spend time with direct care staff and nurses to demonstrate the use of the appliance. Please provide Physical Therapy help sheets, pictures for placement or any other supporting documents that you may have to help our staff.

Name: ______________________________________ Dates Attending: ________________________________

Please indicate type of appliance used: ________________________________________________________________

To what body part is appliance applied? ______________________________________________________________

*** Please clearly mark LEFT and RIGHT on the appliance, prior to arrival to this program. ***

What is worn under the appliance? _________________________________________________________________

What special skin care is required? _________________________________________________________________

Please indicate the schedule for use of the appliance: time on: ______ time off: ______

Appliance may be taken off for the following reasons: __________________________________________________

Is appliance to be: (check any that apply) off during nap/rest hour? _______ off for bathing/swimming?_______

If redness or skin break-down occur under the appliance, can it be left off for a period of time? _________

If so, how long? ___________

Please use the space below for any additional information:

_______________________________________________________________________________________________

_______________________________________________________________________________________________

_______________________________________________________________________________________________

_______________________________________________________________________________________________

_______________________________________________________________________________________________

_______________________________________________________________________________________________

Name of Person Completing Form Relationship to Participant Phone Date

9.2019
Suctioning/ Tracheostomy Questionnaire

Suctioning

Type: [ ] Oral  [ ] Nasal
Equipment used: [ ] Catheter, size__________  [ ] Yankers
How often is suctioning scheduled?: ________________________________________________
If suctioning is not scheduled, what are indications that suctioning is needed?: ________________________________
__________________________________________________________________________________________
Steps on how to suction your participant: (position, supplies, cleaning technique)

1. __________________________________________
2. __________________________________________
3. __________________________________________
4. __________________________________________

Tracheostomy

Type: ___________________ Size: _________________________  [ ] Cuffed  [ ] Uncuffed
"Emergency trach changes will only be administered by a licensed health care professional”?
Participant’s Protocol for Emergency Trach Change: ________________________________________________
___________________________________________________________________________________________
Steps on Trach care and (position, supplies, cleaning technique)

1. __________________________________________
2. __________________________________________
3. __________________________________________
4. __________________________________________

Additional helpful information:
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Name of Person Completing Form Relationship to Participant Phone Date

9.2019