TRUE FRIENDS
Camps. Respite. Programs. Travel.

2021 Camp and Respite Registration

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. Individuals using Waivered Funds: Your most recent Coordinated Service Support Plan (CSSP)/Community 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.

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.

True Friends
10509 108th St. NW
Annandale, MN 55302
952.852.0101

FOR OFFICE USE ONLY: Application Rec'd. / / Deposit Rec'd:
By_____

Camp and Respite Application

General Information – Tell Us About Yourself

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

Name: _____
Last Legal First Name (Nickname) Middle Initial

Address: _____
Street (include Apt. #, if applicable) City State Zip

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: _____Is parent also the guardian?: ___ Yes ___ No

Phone number (_____) _____Cell phone (____)_____Email: _____

Address:_____
Street City State Zip

Place of employment: _____ Work number: (_____) _____
Name of company Position/title

#2 Parent/Legal Guardian name: _____ Is parent also the guardian?: ___ Yes ___ No

Phone number: (_____) _____Cell phone: (____) _____ Email: _____

Address: _____
Street City State Zip

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

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

Medical Assistance #: _____ Medicare #: _____

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
___Anxiety
___Attention Deficit Disorder
___Autism
___Brain Injury
___Developmental-Cognitive or Intellectual Disability
___***DIABETES – Type 2**
___***EPILEPSY/SEIZURES.** If yes, please provide protocols.
___Fetal Alcohol Spectrum Disorder
___MRSA: ___ Active ___ Inactive
___Multiple Sclerosis (MS)
___***ORTHOPEDIC APPLIANCES**
___Parapalegia
___Prader-Willi Syndrome
___Respiratory
___Spina Bifida
___Tourette Syndrome
___Blind ___Vision impaired, no correction
___Deaf ___Hearing impaired, no correction
___Left ear
___Uses Sign Language
___Other disability/diagnosis/condition, please explain: _____

___Alzheimer's or Dementia (Beginning Stage)
___Arthritis
___Attention Deficit Hyperactive Disorder
___Bipolar Disorder
___***CATHETER**
___Depression
___Down Syndrome
___Heart Problems, explain: _____
___Muscular Dystrophy (MD)
___ Obsessive-Compulsive Disorder
___Pica
___Parkinson's
___Quadriplegia
___Rett Syndrome
___Sensory Processing Disorder, explain: _____
___***TRACHEOSTOMY**
___Wears glasses
___Wears hearing aid x 1
___Right ear
___Needs a staff proficient in sign language

___Amputee
___Asthma
___Blood Disorder: _____
___Cerebral Palsy
___***DIABETES – Type 1**
___***FEEDING TUBE**
___Oppositional Defiant Disorder
___ Post Traumatic Stress Disorder
___ Pervasive Developmental Disorder
___ Reactive Attachment Disorder
___Williams Syndrome
___Wears hearing aid x 2

Participant Name: _____ Date of Birth: _____

Allergies

Do you have a food allergy? ___ Yes ___ No If yes, please explain the food allergy and specify your reaction to the food 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 received for a True Friends service 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): _____
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.

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: _____
Explain method for dealing with fears: _____
_____

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

___ Self-injurious behaviors ___Temper tantrums ___ Removes clothing
___ 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 male staff ___ Displays unusual behavior toward female 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?: _____
_____
Are you able to wear a mask indoors when not eating or sleeping?: ___ Yes ___ No
Can you socially distance yourself from others during your time at camp?: ___ Yes ___ No
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: _____
_____

Participant Name: _____ Date of Birth: _____

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: _____
_____

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?: _____

All upper bunkbeds have attached bed rails, as required by American Camp Association standards. Bed rails can be attached to lower bunkbeds, with that in mind: Do you prefer to have a bed rail on the lower bunkbed? ___ Yes ___ No
Do you feel comfortable sleeping on an upper bunkbed?: ___ Yes ___ No
What time do you wake up in the morning, typically: _____ What time do you go to bed, typically: _____
Do you experience night time bed wetting? ___ Never ___ Occasional ___ Weekly ___ Nightly
Further instructions: _____
_____

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.**

Participant Name: _____ Date of Birth: _____

Communication

Able to communicate wants/needs? ___Yes ___No
___ Verbal-speaks clearly ___Verbal-difficult to understand ___Uses a communication device ___Sign Language ___Non-verbal/gestures
___ Uses Picture Exchange Communication System (PECS) Other type of communication device: _____
Understands/responds to questions?: ___Yes ___No
Needs extra time to process information?: ___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 Please explain how: _____
Further instructions:_____
_____

Activity Interests & Abilities

Activity Interests & Abilities*. What activities are you interested in participating in while attending True Friends?
**Activities are seasonal and may not be available for each program.*

Boating ___Yes ___No
Tubing ___Yes ___No
Water skiing ___Yes ___No
Canoeing ___Yes ___No
Kayaking ___Yes ___No
Tent Camp ___Yes ___No
Ride a bike ___Yes ___No
Zip Lining ___Yes ___No
Swimming ___Yes ___No
Fishing ___Yes ___No
Spend time with animals ___Yes ___No
Art ___Yes ___No
Music ___Yes ___No
Drama ___Yes ___No
Cook out or picnic ___Yes ___No
Climbing Wall or Ropes Course ___Yes ___No

What is your 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 have a fear of water?: ____Yes ____No
Do you need ear plugs when in the water?: ____Yes ____No If yes, please bring them to camp.
Do you need a Personal Flotation Device when swimming or wading?: ____Yes ____No Will you swim in a lake?: ____Yes ____No
Are there other activities you want to try?: _____
I really enjoy: _____
_____
I give permission to engage in all activities, except: _____
_____

Tell Us About Your History With True Friends

Have you ever attended True Friends services?: ___Yes ___No
___ Respite ___ Summer/Day Camp ___ Winter Camp ___ Adventure Trip ___ Ventures Travel ___ Team Quest ___ True Strides
___ Conference and Retreat (school or business retreat)
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: _____
___Internet search. Which site: _____

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: _____

_____

**Participants will not be registered for consecutive weeks of residential summer camp sessions; and total sessions registered will not exceed four weeks. Individuals attending Day Camp are excluded.*

Do you have a cabin mate request? Name: _____ (We will do our best to respect your request, but cannot guarantee it.)

Participant Name: _____ Date of Birth: _____

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/applicants 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
- Data Privacy
- Service Suspension
- Maltreatment Reporting
- Service Termination
- Service Recipient Rights
- Emergency Use of Manual Restraint

_____
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

Participant Name: _____ Date of Birth:_____

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:

_____
Name of Payee Address City State Zip

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.

Participant Name: _____ _____
Last First Nickname Middle Initial Date of Birth
Parent/Guardian Name (if applicable): _____ Spouse Name (if applicable): _____
Adj, Gross Income: $_____ Adj. Gross Income of Spouse (if separate returns filed): $_____
Total Number of Dependents (including yourself and spouse if applicable): ____ Total amount you are able to contribute toward the cost: $_____

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.

Examples: Extenuating Circumstances (loss of income, significant out of pocket expense)	**Wage Earner or Dependent Affected**	**Additional hardship since last tax filing**

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

_____
Signature of camper/parent/guardian Date

TRUE FRIENDS
Camps. Respite. Programs. Travel.

2021 Application – Health Care Questionnaires

On Page 2 of the 2021 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.

True Friends
10509 108th St NW
Annandale, MN 55302
Tel: 952.852.0101
registration@truefriends.org
www.truefriends.org

Office Use Only
Session_____
Cabin_____
Cabin Copy____
Nurse Copy____

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 ___ Other: _____

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
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 _____
Only add correction dose if it has been 3 hours since the last insulin administration.

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 does 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.

Managing Very Low/Very High Blood Glucose – resumes on next page.

Managing Very Low Blood Glucose

Hypoglycemia Plan for Blood Glucose less than _____ mg/dl

1. Give 15 grams of fast acting carbohydrates.
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.

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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#:_____
Treating Physician:_____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

Seizure Type	Length	Frequency	Description

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):

Emergency Medication	Medication	Dosage & Time of Day Given	Route of Administration	Common Side Effects

Basic Seizure First Aid:
- Stay calm and track time
- Keep person safe
- Do not restrain
- Do not put anything in mouth
- Stay with person until fully conscious
- Record seizure in log

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

Does person have a Vagus NerveStimulator (VNS)?_____Yes_____No If yes, explain protocols: _____
_____
Special considerations & Safety Precautions (Regarding activities, sports, travel, etc.) _____
_____
_____

Individual Signature:_____Date:_____
Parent/Guardian Signature (if minor):_____Date: _____

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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? _____
Average amount of urine collected during cathing: _____ 24-hour output _____
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:

_____
Person Completing Form | Relationship To Participant | Phone | Date

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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:_____ Type: ☐Mic-Key ☐ Bard Button ☐ 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:						
Amount (ml):						

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

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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

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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