



2022 Travel 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 trip 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 truefriends.org/policy-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. 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 of your CSSP/CSP, receive a service authorization and/or for additional questions.
5. 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.

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
- ___ CSSP/CSP- See #4. (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 _____

Travel 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)
 What size t-shirt do you wear?: ___ XS ___ S ___ M ___ L ___ XL ___ 2XL ___ 3XL ___ 4XL Other: _____

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/policy-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 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 truefriends.org/documents-forms/. The questionnaires must be included when you submit your application and are attached at the end of the application.

- | | | |
|--|--|---|
| <input type="checkbox"/> No Diagnosis/Disability/Condition | <input type="checkbox"/> Alzheimer's or Dementia (Beginning Stage) | <input type="checkbox"/> Amputee |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Attention Deficit Hyperactive Disorder | |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Blood Disorder: _____ |
| <input type="checkbox"/> Brain Injury | <input type="checkbox"/> *CATHETER | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Developmental-Cognitive or Intellectual Disability | <input type="checkbox"/> Depression | <input type="checkbox"/> *DIABETES – Type 1 |
| <input type="checkbox"/> *DIABETES – Type 2 | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> *FEEDING TUBE |
| <input type="checkbox"/> *EPILEPSY/SEIZURES . If yes, please provide protocols. | | |
| <input type="checkbox"/> Fetal Alcohol Spectrum Disorder | <input type="checkbox"/> Heart Problems, explain: _____ | |
| <input type="checkbox"/> MRSA: <input type="checkbox"/> Active <input type="checkbox"/> Inactive | <input type="checkbox"/> Muscular Dystrophy (MD) | |
| <input type="checkbox"/> Multiple Sclerosis (MS) | <input type="checkbox"/> Obsessive-Compulsive Disorder | <input type="checkbox"/> Oppositional Defiant Disorder |
| <input type="checkbox"/> *ORTHOPEDIC APPLIANCES | <input type="checkbox"/> Pica | <input type="checkbox"/> Post Traumatic Stress Disorder |
| <input type="checkbox"/> Paraplegia | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Pervasive Developmental Disorder |
| <input type="checkbox"/> Prader-Willi Syndrome | <input type="checkbox"/> Quadriplegia | <input type="checkbox"/> Reactive Attachment Disorder |
| <input type="checkbox"/> Respiratory | <input type="checkbox"/> Rett Syndrome | |
| <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> Sensory Processing Disorder, explain: _____ | |
| <input type="checkbox"/> Tourette Syndrome | <input type="checkbox"/> *TRACHEOSTOMY | <input type="checkbox"/> Williams Syndrome |
| <input type="checkbox"/> Blind <input type="checkbox"/> Vision impaired, no correction | <input type="checkbox"/> Wears glasses | |
| <input type="checkbox"/> Deaf <input type="checkbox"/> Hearing impaired, no correction | <input type="checkbox"/> Wears hearing aid x 1 | <input type="checkbox"/> Wears hearing aid x 2 |
| <input type="checkbox"/> <input type="checkbox"/> Left ear | <input type="checkbox"/> Right ear | |
| <input type="checkbox"/> Uses Sign Language | <input type="checkbox"/> Needs a staff proficient in sign language | |
| <input type="checkbox"/> Other disability/diagnosis/condition, please explain: _____ | | |

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 record 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 during your stay? (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 truefriends.org/documents-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:

<input type="checkbox"/> Self-injurious behaviors	<input type="checkbox"/> Temper tantrums	<input type="checkbox"/> Removes clothing
<input type="checkbox"/> Uses inappropriate language	<input type="checkbox"/> Inappropriate sexual behaviors	<input type="checkbox"/> History of stealing
<input type="checkbox"/> Physically aggressive toward others:		
<input type="checkbox"/> biting <input type="checkbox"/> slapping <input type="checkbox"/> punching <input type="checkbox"/> kicking <input type="checkbox"/> choking <input type="checkbox"/> spitting		<input type="checkbox"/> Rectal digging
<input type="checkbox"/> Physically aggressive toward property	<input type="checkbox"/> Stubbornness	<input type="checkbox"/> Food related (stealing/eating inedible objects)
<input type="checkbox"/> Elopes/runs away unintentionally	<input type="checkbox"/> Elopes/runs away intentionally	<input type="checkbox"/> Fecal smearing
<input type="checkbox"/> Displays unusual behavior toward male staff		<input type="checkbox"/> Displays unusual behavior toward female staff
<input type="checkbox"/> Exaggerates/fabricates information	<input type="checkbox"/> Suicidal tendencies/thoughts	
<input type="checkbox"/> 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 stay?: Yes No
Do you anticipate any concerns with this participant going out into the community? Yes No If yes, please explain: _____

Do you 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: _____

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 room 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?: _____
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
 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.**

Personal Preferences

Travelers may go to a social function/restaurant where alcohol is served. May traveler have alcohol? Yes No. If yes, what type of alcoholic beverage may be chosen? Beer Wine Liquor Suggested drink limit? (Example: 1 per day): _____
Traveler: manages spending money will check spending money in with staff. Explain any other money management concerns: _____
Traveler smokes: Yes No If yes, traveler manages cigarettes: Yes No *Staff hold cigarettes: Yes
Traveler on cigarette limit: Yes, how many and how often? _____
Traveler enjoys swimming Yes No

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: _____

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/Travel Team Building
 Therapy and Adaptive Riding 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

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: _____

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
- 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.
- I do not have to consent to the release of information.

Signature Date

Participant Name: _____ Date of Birth: _____

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 truefriends.org/policy-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 truefriends.org/policy-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.

Medication Administration and Emergency Medical Authorization

Please review and sign to provide your understanding of the information below. To read the full policy visit truefriends.org/policy-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 _____

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 952.852.0130, 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
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Travel Cancellation Policy

Vacations which require pre-paid purchases (airline tickets, hotel rooms, etc.) have strict cancellation policies set by airline, cruise or train companies. True Friends has no control over these penalties; therefore our cancellation policies must reflect their restrictive guidelines. If a traveler wishes to cancel their trip, any non-refundable expenses will not be refunded to the traveler. If you wish to cancel your trip you MUST notify us by email or letter. Phone conversations or voice mail messages are insufficient notification, and if no formal notice is received, we will consider you a 'no show'.

Additional & Fluctuating Costs

Travelers are responsible for additional expenses incurred on their behalf during a vacation including but not limited to: property damage, overweight or excess luggage, pay-per-view television charges, phone charges, prescription re-fills, personal care items, equipment rentals, and travel expenses related to travel disruption or delay. Trips may be cancelled due to low registrations. True Friends will provide a full refund if this occurs or transfer any fees paid to the vacation of your choice.

Airline and rail services adjust their schedules for many reasons. When this occurs, True Friends reserves the right to adjust your itinerary accordingly and will notify you as soon as possible. Prices for trips which include travel by air or train are based on capacity controlled costs. In the event that we are unable to secure seats due to conditions beyond our control, such as strikes, schedule, or regulation changes, we reserve the right to contact each guest to pay an additional fare or notify of a schedule change.



2022 Application – Health Care Questionnaires

On Page 2 of the 2022 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

- Always use the insulin pump bolus wizard: Yes No
 If no, use insulin carbohydrate ratio and correction factor dosage on Plan B.
- 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
- The insulin pump will calculate the correction dose to be delivered before the meal/snack.
- 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.
- 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

- Participant will receive a fixed dose of: _____ long-acting insulin at _____ am/pm Yes No
- Follow blood glucose monitoring plan above.
- Use _____ insulin for meals and snacks. Insulin dose for food is: _____ unit(s) for meals OR _____ unit(s) for every _____ grams carbohydrate.
- 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

- Child will receive a fixed dose of long acting insulin? Yes No
 If yes, give participant _____ unit(s) of _____ insulin at _____.
- Insulin correction dose at camp (_____ insulin)?
- 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 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

Does person have a Vagus Nerve Stimulator (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: _____

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



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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