



## 2024 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 <https://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. 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](mailto: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
- \_\_\_ Deposit (if applicable)
- \_\_\_ CSSP/CSP- See #5. (if applicable)
- \_\_\_ Adoption Assistance Reimbursement Letter (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 108<sup>th</sup> 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)  
 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](http://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 see the camp/respite catalog for more information or visit [www.truefriends.org](http://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/documents-forms/](http://www.truefriends.org/documents-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**
- \_\_\_ Paraplegia
- \_\_\_ Prader-Willi Syndrome
- \_\_\_ Respiratory
- \_\_\_ Spina Bifida
- \_\_\_ Tourette Syndrome
- \_\_\_ Blind
- \_\_\_ Deaf
- \_\_\_ 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**
- \_\_\_ Williams Syndrome
- \_\_\_ Wears hearing aid x 2
- \_\_\_ Oppositional Defiant Disorder
- \_\_\_ Post Traumatic Stress Disorder
- \_\_\_ Pervasive Developmental Disorder
- \_\_\_ Reactive Attachment Disorder

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/documents-forms](http://www.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:             |   |  |
| ___ biting ___ slapping ___ punching ___ kicking ___ choking ___ 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 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: \_\_\_\_\_

**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 Fishing  Yes  No  
Tubing  Yes  No Spend time with animals  Yes  No  
Water skiing  Yes  No Art  Yes  No  
Canoeing  Yes  No Music  Yes  No  
Kayaking  Yes  No Drama  Yes  No  
Tent Camp  Yes  No Cook out or picnic  Yes  No  
Ride a bike  Yes  No Climbing Wall or Ropes Course  Yes  No  
Zip Lining  Yes  No  
Swimming  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\*:**

1<sup>st</sup> choice: \_\_\_\_\_ 2<sup>nd</sup> choice: \_\_\_\_\_  
3<sup>rd</sup> choice: \_\_\_\_\_ 4<sup>th</sup> choice: \_\_\_\_\_

Do you want to attend each session listed above, if possible?:  Yes  No  
*If no, we will process your application in your session preference 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; the number of sessions confirmed per participant may be limited due to session availability and consecutive day limits.*

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 <https://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 [www.truefriends.org/policy-procedures](http://www.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.

\_\_\_\_\_  
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/policy-procedures](http://www.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. When your name or story is utilized for promotional purposes, a member of True Friends will contact you for awareness and consent.

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 medium.*

\_\_\_\_\_  
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. You will be prompted to pay a deposit once you have been placed in a session.**

I will be privately paying for services?  Yes  No  Full payment enclosed  Deposit enclosed

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



## **2024 Application – Health Care Questionnaires**

On Page 2 of the 2024 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. Completed questionnaires can be emailed to [registration@truefriends.org](mailto:registration@truefriends.org).

If you have any questions about the questionnaires please email [registration@truefriends.org](mailto:registration@truefriends.org) or 952.852.0101.



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## 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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 10509 108<sup>th</sup> St NW  
 Annandale, MN 55302  
 Tel: 952.852.0101  
[registration@truefriends.org](mailto:registration@truefriends.org)  
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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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Session \_\_\_\_\_

Cabin \_\_\_\_\_

Cabin Copy \_\_\_\_\_

Nurse Copy \_\_\_\_\_

## Suctioning/ Tracheostomy Questionnaire

Participant Name: \_\_\_\_\_ Dates Attending: \_\_\_\_\_

### 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