



EXCEPTIONAL ADVENTURES

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2018

Guest Information Sheet

Guest Name: _____

Guest #: _____

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

GENERAL INFORMATION:

Today's Date: _____

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

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

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

Birthdate: _____ Social Security #: _____

Guest Address 1: _____ Phone: _____

(Address line 2): _____ Phone: _____

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

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

Other Address: _____ Phone: _____

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

SUPPORTS COORDINATION INFORMATION:

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

AGENCY INFORMATION (IF APPLICABLE):

Agency Name (Where do you reside?): _____

DOES THE GUEST HAVE:

Walking Problems:

Walks on All Surfaces: Yes: No:
Has Difficulty on Stairs: Yes: No:
Uses a Wheelchair: Yes: No:
Uses a Walker or Cane: Yes: No:

Stands To Transfer: Yes: No:
Transfers In/Out of Wheelchair: Yes: No:
If "No", specify assistance needed:

Respiratory Problems:

Has Asthma: Yes: No:
 Has COPD: Yes: No:
 On Oxygen: Yes: No:

C-PAP: Yes: No:
 Nebulizer: Yes: No:
 Other: _____

Heart Problems:

High Blood Pressure: Yes: No:
 Has a Pacemaker: Yes: No:
 Has had a Heart Attack: Yes: No:
 Has had a Stroke: Yes: No:
 On Coumadin? Yes: No:

If "Yes", Provide Date: _____
 If "Yes", Provide Date: _____

Epileptic / Seizure Activity:

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

Has VNS Yes: No:
 (*Vagus Nerve Stimulation*)

Special Instructions: _____

Diabetes:

Has Diabetes Yes: No: If "Yes", Requires Oral Medication? Yes: No:
Insulin Injection? Yes: No:

Special Instructions: _____

 Special Diet: _____

Special Dietary Needs:

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

Vision / Speech / Hearing Problems:

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

Emergency / After-Hours Contact(s):

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

	<u>First Name</u>	<u>Last Name</u>	<u>Phone:</u>	<u>Cell:</u>
Contact #1:	_____	_____	_____	_____
Contact #2:	_____	_____	_____	_____
Contact #3:	_____	_____	_____	_____

Medications / Special Medical Needs:

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

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

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

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

Consent to Photograph:

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

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

- If "Yes", pick one -->**
- _____ Permission to Photograph --- no names
 - _____ Permission to Photograph --- use of first name
 - _____ Permission to Photograph --- use of first and last name

Name of person filling out this form: _____

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

Phone #: _____

SIGNATURES:

Guest Signature

Date

Appointed Guardian or Person Assisting with this Form

Date