**PARTICIPANT REGISTRATION FORM**

Please complete for each person participating and return by mail, fax, or email.

**Traveler Registration**

|  |  |
| --- | --- |
| Full Legal **Name of Participant:** |  |
| Date of Birth |  |
| Home Address |  |
| City  |  | State |  | Zip |  |
| Phone Numbers | 1 |  | 2 |  |
| Billing Address (if different)  |  |
| City  |  | State |  | Zip |  |
| Email Contact for Traveler, or Traveler’s Support Person, or Traveler’s Agency |  |
| Emergency Contact - Name |  |
| Phone Numbers (24-Hour Line) | 1 |  | 2 |  |

**Medical History**

|  |  |
| --- | --- |
| Medical Insurance (for Emergency only) |  |
| Policy or Group Number |  |
| Physician Name |  |
| Physician Phone |  |
| **List ANY Known Allergies:** |  |
| Dates of Covid-19 vaccinations |  |
| Date of last Tetanus shot |  |
| Is traveler able to wear a mask for prolonged periods of time? | Yes |  | No |  |
| History of Hepatitis? | Yes |  | No |  |
| Any Communicable Conditions? | Yes |  | No |  |
| **Does Traveler take medications**? | Yes |  | No |  |
| If yes, can Individual self-medicate? | Independent |  | Needs Assistance |  |
| Traveler holds his/her own Medications in their possession while on trip | Yes |  | No |  |
| Can Traveler take over-the-counter Pain medication (e.g., aspirin): | Yes |  | No |  |
| Can Traveler take over-the-counter Antacid for stomach upset? (e.g., Tums, Pepto Bismol) Indicate if preference of type: | Yes |  | No |  |
| Can Traveler take over-the-counter Anti-diarrheal medication? (e.g., Immodium AD) Indicate if preference of type: | Yes |  | No |  |

**Dietary Needs**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Regular Diet (If Yes, skip to Daily Living Needs Section) | Yes |  | No |  |
| Special Restrictions | **Diabetic** |  | **Puree** |  | **Lactose Intolerant** |  | **Other** |  |

Mark and complete those dietary restrictions that apply:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Diabetic** |  | Type I |  | Type II |  |
| **Insulin Shot** | **Yes** |  | No |  |
| Oral Medication | Yes |  | No |  |
| Completes Daily Blood-Sugar Test | Yes |  | No |  |
| Has Own Machine | Yes |  | No |  |
| Sugar Intake | Sweets in Moderation |  | None |  |

|  |  |  |
| --- | --- | --- |
|  | **Puree** | (Special Instructions):  |
| All Meals must be smoothie-like or of milkshake consistency | Yes |  | No  |  |
| Meals must be soft and may be cut into very small bites | Yes |  | No |  |
| Traveler has a thickener supplement for all thin liquids | Yes |  | No |  |

|  |  |  |
| --- | --- | --- |
|  | **Lactose Intolerant** |  |
| Dairy Intake | Dairy in Moderation |  | None |  |
| Traveler has a lactose digestive aid taken with each meal | Yes |  | No  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Sensitive to Caffeine | Yes |  | No |  | Other: |
| Can Participant Consume Alcoholic Beverages? | Yes |  | No |  |
| Other **food** **allergies**, issues, or drink restrictions |  |
| Other Special Dietary Instructions |  |

**Daily Living Needs**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Full Support | Minimal Support | Needs Reminders | Independent |
| Handling Money |  |  |  |  |
| Eating |  |  |  |  |
| Toileting |  |  |  |  |
| Bathing |  |  |  |  |
| Dressing |  |  |  |  |
| Tooth Brushing |  |  |  |  |

**Physical Needs**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Satisfactory (No Issues) | Mildly Impaired | Moderately Impaired | Severely Impaired (Total Loss) |
| Vision |  |  |  |  |
| Hearing |  |  |  |  |
| Walks Independently |  |  |  |  |
| Climbing Stairs |  |  |  |  |
| Traveler has Epilepsy/**Seizures** | Yes |  | No |  | Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other Mobility Needs: |  |

If Traveler needs walking supports or has other mobility issues, please complete this section:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Uses Walker or Cane | Yes |  | No |  |
| Uses Manual Wheelchair | Yes |  | No |  |
| Uses Electric Wheelchair | Yes |  | No |  |
| Can Traveler transfer into Bed, Bath or Toilet with Assistance | Yes |  | No |  |
| Can Traveler transfer onto a Bus or Plane with Assistance | Yes |  | No |  |

|  |
| --- |
| Special Likes and Dislikes: |
|  |
|  |
| Personality/Behaviors: |
|  |
|  |
|  |
| Other Travel Concerns/Instructions: |
|  |
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**PARTICIPANT MEDICATION FORM**

* **Please fill out this section completely and accurately for each Traveler for the identified Trip or Travel Date, and return by mail, fax, or email.** List **ALL** medications to be taken and check the boxes for each time it should be administered. In addition to prescription medication, list pain relievers, antacid, or over-the-counter medications taken regularly.
* Be sure that all medications are also clearly labeled with person’s name, medication, dosage and times. Make sure you send the correct amount of medications for the time needed and that you hand them directly to our staff.
* It is strongly recommended to arrange for vacation bubble packs for all Travelers on trips covering more than one day. This can be arranged through your pharmacy. A separate bubble package is created by the pharmacy that will cover only the days of the trip.

|  |  |
| --- | --- |
| Full Legal **Name of Participant:** |  |
| Date of Birth |  |
| **Travel Dates of Trip:** |  |
| **Date of Covid-19 vaccination:** |  |
| Contact name and number of someone we can call with questions about this form | Name |  |
| Phone |  |
| Traveler is able to wear a mask | Yes |  | No |  |
| Traveler takes Medications (If no, skip to Signature) | Yes |  | No |  |
| Traveler holds his/her own Medications | Yes |  | No |  |
| List of Medications (or MAR) is provided in place of the following list | Yes |  | No |  |
| **MEDICATION/PURPOSE (please provide name of medication and why it is taken)** | **8 AM** | **NOON** | **4 PM** | **8 PM** | **Other (indicate time)** |
|  |  |  |  |  |  |
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Completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SPECIAL VACATIONS, INC. PARTICIPANT CONSENT AND RELEASE FORM**

This Consent and Release is entered into this \_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,2022, by (Participant, parent, legal guardian, or authorized agent) of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Participant; all references herein to I, me or my, or any extension thereof shall include the participant and his or her parent/legal guardian or legally authorized agent). Whereby for good and valuable consideration, I agree to the following terms and conditions and to the Release of Special Vacations, Inc, its officers, directors, employees, volunteers, advisors, agents, successors and assigns (collectively, “Special Vacations”) contained herein.

**CONSENT TO PARTICIPATION AND MEDICAL TREATMENT**

1. I represent and agree that I have the legal capacity and authority to act on my own behalf and for and on behalf of the participant, if applicable. This Consent and Release shall be binding on me, my heirs and assigns.
2. I acknowledge that the activities included in Special Vacations programs involve certain risks, inherent in those activities, including but not limited to personal injury, sickness and/or damage to and/or loss of property. I agree and voluntarily assume such risks of personal injury, sickness (including any communicable disease) and/or death to myself, and/or damages to and/or loss of my property, caused by or arising out of my involvement in Special Vacations programs. I am, or certify that the participant is, physically and mentally capable of participating in the Special Vacations programs.
3. As a condition of my participation in the Special Vacations program, I will abide by safety rules and instructions provided in writing or verbally to me. If I fail to follow the rules or instructions, I will be removed from Special Vacations program without refund.
4. I agree that I may be transported by the Special Vacations personnel to and from its programs and for various activities and I agree to assume all risks in relation to such transportation.
5. I authorize any licensed physician, emergency medical technician, paramedics, nurses, medical or health care facility or provider (“Medical Provider”) to provide medical care to me for injuries and/or conditions that occur, manifest or arise during a Special Vacations program. I further authorize such Medical Provider to perform all procedures or services deemed medically advisable to treat or relieve, or to attempt to treat or relieve, any illness, injury, and/or condition. I acknowledge that there is a possibility of complications and unforeseen consequences in any medical treatment, and I knowingly and voluntarily agree to assume such risk for and on behalf of myself and/or the participant.

**RELEASE AND INDEMNIFICATION**

1. Special Vacations may at times use unspecified participant travelers in media distribution and promotional use. Release is subject to use of likeness, photo, video, name, or voice in materials both publicly distributed and publicly available (such as website).
2. Special Vacations shall not be liable for damages arising from personal injuries (including death) to me or damage to or loss of property or other harm, whether foreseen or unforeseen, present or future, known or unknown, which directly or indirectly results from or arises out of my participation in a Special Vacations program (collectively the “claims”). I understand that THIS RELEASE, INCLUDES CLAIMS BASED IN WHOLE OR IN PART ON THE NEGLIGENCE, ACTION OR INACTION OF SPECIAL VACATIONS AND HEREBY RELEASE, WAIVE AND FULLY DISCHARGE SPECIAL VACATIONS FROM ALL LIABILITY FOR CLAIMS.
3. I HEREBY INDEMNIFY, DEFEND AND HOLD HARMLESS SPECIAL VACATIONS FROM AND AGAINST ALL CLAIMS, COSTS, EXPENSES (INCLUDING ATTORNEY FEES), LIABILITIES AND DAMAGES, THAT I OR MY HEIRS AND ASSIGNS MAY HAVE OR ASSERT, EVEN IF CAUSED IN WHOLE OR IN PART BY THE NEGLIGENCE, FAULT, BREACH OF CONTRACT, OR OTHER ACT OF SPECIAL VACATIONS OR, AS A RESULT OF, RELATED TO OR ARISING OUT OF (1) ANY INSUFFICIENCY OF MY LEGAL CAPACITY OR AUTHORITY TO ACT FOR MYSELF OR THE PARTICIPANT IN THE EXECUTION OF THIS CONSENT AND RELEASE, (2) ANY TREATMENT OR FAILURE TO TREAT ME OR THE PARTICIPANT BY ANY MEDICAL PROVIDER, AND/OR (3) THE DISCLOSURE OF ANY MEDICAL INFORMATION OR RECORDS FOR USE IN THE MEDICAL TREATMENT OF MYSELF OR THE PARTICIPANT.
4. This Release is governed by the laws of the Commonwealth of Pennsylvania and is intended to be as broad and inclusive as permitted by law, and if any portion thereof is held invalid, the balance shall continue in full legal force and effect.
5. This Release is not intended to release the Released Parties from any conditions or activity that, as a matter of law, cannot be avoided, waived or released and no provision of this Release should be interpreted as such.

**STAFFING AND SUPPORT SERVICE**

1. Participants who bring support staff: Special Vacations does not provide support and safety supervision, with the exception of transfers for non-mobile Participants, at any time during the tour, trip, or activity, for Participants accompanied by their own support staff, including family members traveling as support staff for the Participant. Support staff (or family members) accompanying the Participant and performing support duties are expected to provide all necessary support for the Participant at all times over the duration of the tour.
2. What is being provided as part of a group: Special Vacations provides support and safety supervision, including transfers for non-mobile Participants, at all times during the tour, trip, or activity. Support supervision is provided in group settings as arranged at time of registration.

**I HAVE READ AND UNDERSTAND THE FOREGOING CONSENT AND RELEASE AND ACCEPT AND AGREE TO ITS TERMS VOLUNTARILY.**

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**SIGNATURE** OF PARTICIPANT OR LEGAL GUARDIAN Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRINTED NAME** OF PARTICIPANT OR LEGAL GUARDIAN