INDIVIDUAL PACKET

Thank you for your interest in **BREAKAWAY.** All of the application pages that follow must be completed, with applicant's signature and returned with $100 deposit to our Office or email at: MO.Breakaway@liftdisability.net. Credit card payments can be made on our website liftdisability.net/mo-breakaway-pay

If someone else or an organization is paying your way, ask them to clearly mark the payment with your name in the memo section of the check. Checks should be made payable to Lift Disability Network

Dear Friend: We are excited that you are considering joining us for BREAKAWAY. This week will give you an opportunity to find kindred spirits that understand the uniqueness of living with disability. Equipped volunteers will assist you with personal care needs as well as spiritual needs to assure you a week of relaxation, spiritual renewal and fun. This week is sure to give you memories and friendships that will last a lifetime.

The cost to you for this unforgettable week is just **$300.00**.

Please use the following check list to complete your application:

- ☐ Please read all materials included in this packet.
- ☐ Complete each portion of the application.
- ☐ Include any additional information you think we should know. We cannot guarantee, but we do welcome any and all housing requests.
- ☐ Include a recent picture of the applicant with name clearly marked.
- ☐ Sign and include your **$100 non-refundable deposit** (or full payment if desired.) **A Second $100/person payment (or full remaining balance if desired) is due on May 11th. Any remaining balance is due June 11th .**
- ☐ Contact our office to obtain a Sponsorship Application if necessary. **If you are applying for a scholarship our office will contact you if you have been approved.**
- ☐ Mail your completed application with deposit to our office.
- ☐ Have your **physician complete and sign** the **Medical History Report** of the application.
- ☐ MEDICATION POLICY: **Bubble Packed from the pharmacy is preferred. All medications must be turned in and be clearly labeled with recipient, medication, dosage, frequency, route, prescribing physician, RX#, pharmacy info and expiration date.** Pre-poured, daily containers are not acceptable. Breakaway Nurses will administer all medications and vitamins as directed by physician on original pharmacy label.
- ☐ **Included a COPY (not the original) of Medical Assistance and / or Medicare cards.**

We reserve the right to refuse acceptance of any applicant, based on our ability to provide adequate care according to the applicant's needs.

☐ If accepted, approximately 3 weeks before BREAKAWAY you will receive a packet of information with directions, schedule and suggested packing ideas.

If you have questions, please contact the **Delaine Young at 314-956-2665 or email** **MO.Breakaway@liftdisability.net**.

2019 APPLICATION FOR INDIVIDUAL

OFFICE USE ONLY Tuition PD $ ________
Check #_______ Tuition Due $ ______
Emerg ___ Guard ___ Med ___
Allergies: Food ___ Med ___ Other ___
Disability: CD CD/PH PH
Wheelchair: M E SR _____
Photo _____ Roommate Request ______________
Scanned: ____________________________

PLEASE TYPE OR PRINT. In order to reserve you spot please complete the **entire** application. Send all forms with $100 deposit and a recent photo to Lift Disability Network, PO Box 302, Foristell, MO 63348. Applications with missing or invalid information will be considered incomplete.

INDIVIDUAL APPLICATION | Information
Please put as many details as possible. These answers will help us to provide you with the most enjoyable week possible.

Location of BREAKAWAY: Lake Yale Conference Camp Wartburg, July 3-6	Legal Name (Last, First, Middle):	Preferred Name (for Name Tag):
Physical Address:	City, State:	Zip Code:
Primary/Home Phone:	Cell Phone:	
Email Address:		
Date of Birth:	Height:	Weight:
Gender: M ☐ F ☐	Age:	Married: ☐ Yes ☐ No
I Reside at: ☐ own home/apt. ☐ Family Home or ☐ Name of Residence:	☐ I am my own Guardian. Or, Name of Legal Guardian:	
Relationship of Guardian:	Phone:	Evening Phone:
Address:	City, State & Zip:	

IF MY LEGAL GUARDIAN IS NOT AVAILABLE IN AN EMERGANCY, PLEASE NOTIFY

Name:	Relationship:	Phone:
Have you attended BREAKAWAY in the past? ☐ Yes ☐ No		
Pastor's Name:	Home Church:	
Church Address:	City, State & Zip:	

GUARDIAN PERMISSION

I hereby give permission as legal guardian, for the individual named above to attend Breakaway. To the best of my knowledge, the information on the Ability Evaluation and the Medical History Report is correct and this individual has permission to engage in all activities, except as noted by myself and/or the Health Care Professional. I further understand that Lift Disability Network reserves the right to reject any applicant whose needs cannot be met by our staff or Crew Members.

I understand that due to some state laws, **ALL** medications and/or vitamins brought to Breakaway **MUST** be in their **original prescription containers, clearly labeled with the recipient, medication, dosage, frequency, route, prescribing physician, RX#, pharmacy info, expiration date and not in pre-poured containers.** Pharmacy bubble packs are preferred. Pre-poured daily containers are not acceptable.

I agree to relieve all Lift Disability Network personnel and its corporate entities from liability in connection with Breakaway.

If I cannot be reached in an emergency, I hereby give permission to the Health Care Professional selected by the Breakaway staff to hospitalize, secure proper treatment, and to order injection, anesthesia, surgery or other medical care for this individual. I will assume all financial responsibility for any medical treatment required.

If applicant displays inappropriate behavior which causes dismissal, legal guardian, or residence assumes immediate responsibility for transportation and its cost to return this individual home, and no refunds will be given. I agree not to send this individual if exposed to a contagious disease within three weeks of the event, and I will notify Breakaway if this individual must cancel.

Permission is given only to Breakaway and its corporate entities to use photographs (individual or group) and/or multi-media images and recordings in the best interest of said organization. I understand pictures I take at Breakaway are for personal use only. Personal internet use of any video/media should be approached with caution with regard to misrepresentation.

No one will be denied attendance to a Breakaway because of religion, creed, national origin, sex, age, or disability.

I realize that tobacco, alcohol, and illegal drugs are NOT ALLOWED.

Signature of Legal Guardian ______________________________ Date _______________

(Or Applicant Signature if own legal guardian)

ABILITY EVALUATION

#1 Please check all that apply ☐ **Applicant Does Not have a Physical Disability - Please skip to Box #2**

DIAGNOSIS AND OTHER FACTORS

☐ Brain Trauma ☐ Muscular Dystrophy ☐ Heart Condition ☐ Stroke ☐ Cerebral Palsy
☐ Multiple sclerosis ☐ Diabetes – Type ______ ☐ Seizures (see Medical History Form)
☐ Epilepsy ☐ Spina bifida ☐ Spinal Cord Injury ☐ Blind ☐ Visually Impaired
☐ Wears Glasses ☐ Will Bring Service Dog ☐ Deaf ☐ Hearing Impaired
☐ Wears Hearing Aids ☐ Non-verbal ☐ Uses Sign Language
☐ Cannot climb ☐ Can sleep in top bunk

SELF HELP AND SUPERVISION

☐ Lives Independently – No assistance needed
☐ Will require some assistance
- ☐ Minimal
- ☐ Moderate
- ☐ Individual

I WILL PROVIDE MY OWN STAFF/CAREGIVER *

Fill in the information for your staff
☐ Male ** ☐ Female **
Name: ______________________
Address: ____________________
City: ___________________State: _____ Zip: _______

** Staff/Caregiver's completed Crew Application must be submitted with this application*

*** Unless related, staff must be of same sex as applicant*

#2 Please check all that apply ☐ **Applicant Does Not have an Intellectual Disability - Skip to Activities**

INTELLECTUAL ABILITIES AND OTHER FACTORS

☐ High functioning ☐ Down syndrome ☐ Cannot climb stairs ☐ Can sleep in top bunk
☐ Mild ☐ Blind ☐ Visually Impaired ☐ Wears Glasses
☐ Moderate ☐ Deaf ☐ Hearing Impaired ☐ Wears Hearing aid
☐ Severe/Profound* ☐ Uses Sign Language ☐ Non-verbal

**Our programming is not designed for those with severe/profound disabilities. For further information regarding this, please contact our office.*

☐ Autistic Behavior – *describe:*

SELF HELP AND SUPERVISION

☐ Lives Independently – Needs minimal supervision

☐ Will require some assistance for:
- ☐ Some activities:
- ☐ All activities

☐ Will require individual staff supervision due to:
____
- ☐ Wheelchair manipulation
- ☐ Intellectual disability
- ☐ Poor behavior – *explain:* _________________

ACTIVITIES

Water Sports: ☐ Swims shallow ☐ Swims deep ☐ Uses flotation ☐ Does not swim ☐ Afraid of water
Comments:
Activities applicant enjoys:
Recreational activity applicant CANNOT participate in:

ABILITY EVALUATION -- Please check all that apply

MOBILITY

Walks: ☐ alone ☐ needs assistance ☐ non-ambulatory
Gait: ☐ stable ☐ unsteady ☐ falls easily ☐ slow ☐ medium ☐ fast
Uses and will bring
☐ cane ☐ walker ☐ braces ☐ crutches ☐ electric wheelchair ☐ manual wheelchair
☐ can manipulate wheelchair alone ☐ cannot manipulate wheelchair alone ☐ uses wheelchair only part time

☐ paraplegic ☐ quadriplegic ☐ bears own weight ☐ transfers Alone ☐ transfers with assistance
☐ uses mechanical lift. (Please bring your own lift)

SPECIAL EQUIPMENT -- All *Special Equipment must be brought with you*
☐ splints ☐ prosthesis ☐ helmet ☐ bed rail ☐ Hoyer Lift ☐ other: ____________________
Please explain usage: ____

EATING
Appetite: ☐ large ☐ medium ☐ small ☐ limit helpings to: __________________________
☐ independent - needs no assistance ☐ dependent ☐ needs assistance with:
☐ has difficulty swallowing ☐ solids ☐ liquids
☐ must use straw *(Please provide a weeks supply of disposable bibs & straws if needed)*
☐ must have chopped foods only ☐ must have pureed foods only ☐ eats excessively slow / fast
Allergic to foods listed: ____
Diet restriction that CANNOT lapse during Breakaway: _____________________________________

COMMUNICATION
☐ verbal, has no difficulty ☐ has difficulty expressing self ☐ understands directions and prompts
☐ difficulty understanding directions ☐ slow to communicate needs ☐ uses gestures
☐ non-verbal -- uses sign language *(Please attach a description of signs)*
☐ uses own language board (*Please send with applicant)*
Comments: (use separate page if necessary)____

SELF CARE & DRESSING
☐ independent - needs no assistance
☐ assistance is needed because applicant is ☐ slow ☐ needs prompts
☐ cannot dress self without assistance *Please explain:* ___________________________________
☐ totally dependent
☐ needs help with personal hygiene *Describe assistance needed:* ______________________________
Usual bedtime habits: Goes to bed at what time: ________ Awakens at what time: _____________________
Special sleeping habits: ____
☐ written instructions for specific care needs are listed on a separate page. Verbal instructions are inadequate

TOILET NEEDS - *Please send an adequate supply of materials for these needs.*
☐ independent - needs no assistance
☐ needs assistance with: ____
☐ totally dependent *(Please provide adequate supplies)*
☐ uses incontinence products ☐ at all times ☐ only at night *(Please bring enough for the entire week)*
☐ catheter ☐ colostomy ☐ incontinent: ☐ bowel ☐ bladder *(incontinence products will be used)*
☐ wets the bed *(Please supply adequate bedding, clothing, and/or incontinence products as laundry is not done during Breakaway)*
Female guest is able to care for menstruation ☐ fully ☐ partially ☐ not at all ☐ expected during week

BEHAVIOR -- Please *check all that apply*
☐ generally happy ☐ compliant ☐ social ☐ helpful ☐ cooperative ☐ team player
☐ generally unhappy ☐ non-compliant ☐ withdrawn ☐ prone to depression
☐ does well in large groups ☐ does NOT do well in large groups
☐ cautious/shy ☐ wanders *(Note: applicant who wanders off may be sent home for safety)*
☐ physically abusive / aggressive ☐ to self ☐ to others ☐ to staff
Adapts to new environment ☐ quickly ☐ slowly
Explain other behaviors: ____
____
Are there any behavior problems you handle in specific ways and would like us to continue?
____
____

We ask this because we will try to be consistent with the expectations and discipline at home.

2019 BREAKAWAY – MEDICAL HISTORY REPORT

This medical form must be completed and signed by a physician. RN, LPN, QMRP signatures are NOT acceptable. All applicants must have a medical examination within twelve months prior to date of BREAKAWAY.

PLEASE TYPE OR PRINT

Legal Name (Last, First, Middle):			
Gender: ☐ Male ☐ Female		Date of Birth:	
Height:	Weight:	Blood Pressure:	
Medical Diagnosis of Disability:			
Explanation / Onset / Cause of Disability:			
Applicant's Current Health Condition:			
Allergies: ☐Penicillin ☐Aspirin ☐Latex ☐Hay Fever ☐Bee stings ☐ Other:			
FOOD Allergies:			
Diseases/Past Illnesses: ☐Diabetes ☐Asthma ☐Chicken Pox ☐Tuberculosis ☐Other:			
IMMUNIZATIONS: Tetanus (Must be within 10 years) Date	HBV Date 1	HBV Date 2	HBV Date 3
Surgeries/Serious Illness:	Date:	Date:	
Chronic/Recurring Illness:	Date:	Date:	
Seizures ☐No ☐Yes	Frequency:	Date of last seizure:	Controlled by medication:
Describe seizure:			
Are there any blood/body fluid precautions we should know about? ☐No ☐Yes, describe:			
Activities applicant should not participate in:			

For Applicants 18 Years & Under

DPT/DT/TD Date 1:	Date 2:	Date 3:	Date 4:	Date 5:
POLIO Date 1:	Date 2:	Date 3:	Date 4:	Date 5:
MMR Date 1:	Date 2:	Date 3:	Date 4:	Date 5:
HBV Date 1:	Date 2:	Date 3:	Date 4:	Date 5:

MEDICATION

MEDICATION NAME	**DOSAGE**	**FREQUENCY**	**TIMES**
Example: Dilantin chewable	*two 50mg tablets*	*4 Times daily*	*8am, noon, 5pm, bed*

PHYSICIAN PERMISSION

I have examined the applicant named above and have reviewed their health history. It is my opinion that they are physically able to engage in all **BREAKAWAY** functions through the end of the calendar year, except as noted above.

Physician's Printed name ____

Physician's Signature ____________________________ **Date** ______________

RN, LPN, QMRP signatures are NOT acceptable.

Physician's Address ______________________________ Phone ______________

City____ State ____ Zip ______

MAIL COMPLETED APPLICATION WITH GUARDIAN SIGNATURE, PHYSICIAN'S SIGNATURE AND $100 DEPOSIT MADE PAYABLE TO:

Lift Disability Network | PO Box 302 | Foristell, MO 63348