

SUMMER GET AWAY GENERAL INFORMATION

- Complete ALL information, include any additional pertinent information
- Signature from Guardian Required
- Include Medical Release Form with Physician's Signature
- Include \$100 deposit check or full tuition
OR Make online payments at: www.specialtouch.org/getaways
- Full Payment is due by listed date (One month prior to Get Away)
- Mail to: *Special Touch Ministry, PO Box 25, Waupaca, WI 54981*
If PAYING DEPOSIT/TUITION ONLINE - You may Fax application to 715-258-2777
OR Scan application in PDF format and email to centralprocessing@specialtouch.org
- A picture of applicant with name is helpful (no larger than 4x6)

INCOMPLETE APPLICATIONS OR MISSING DEPOSIT WILL NOT BE PROCESSED UNTIL COMPLETE

ACCEPTANCE

We reserve the right to refuse any applicant based on our ability to provide adequate care in conjunction with applicants needs with regard to our staff, grounds limitations and programming. Acceptance confirmation letters will be mailed from the Coordinator no later than two weeks prior to the start date of the Get Away.

MEDICAL INFORMATION

- Applicants required to have medical exam within 12 months prior to date of Get Away
- PHYSICIANS - Use Medical Release form provided. Additional information is welcome
- ALL MEDICATIONS must be in their original prescription bottle
- Pharmacy prepackaged and labeled medications are accepted
- All medications will be poured, passed and charted by trained medical staff
- Applicants over 50# needing transfers will be lifted with mechanical assistance
- Medical and Behavioral incidents will be documented

SPECIALIZED ATTENDANCE INFORMATION

- Applicants under age 10 must be accompanied by parent/guardian
- No Charge for one Parent/Guardian/Spouse providing care for applicant
- If providing your own Caregiver (paid or unpaid) - Mark the appropriate area on the Guest Application and caregiver/staff must complete a Special Touch Staff Application
- Attending as a Family Unit - See family discount on Guest Application - deposit required

TRANSPORTATION/REGISTRATION

Transportation to and from the grounds is the applicant's responsibility.
Return transportation must be **punctual** since the grounds will be cleared.

PROTECTION

We conduct yearly screening and background checks on all volunteer staff for the safety of our vulnerable population, for the protection of our staff and for the integrity of our organization. All participants are provided limited insurance against injury and illness for the duration of the Summer Get Away.

ADDITIONAL INFORMATION

- Minimum \$100 deposit, non-refundable is required to register
- Full refund if Special Touch is unable to accept an applicant
- Receipt of Application letter will include a Receipt for payments
- Refunds or overpayments will be returned to applicant - \$5.00 processing fee
- No tuition refunds for cancellation less than 2 weeks in advance
- Billing to Service Agencies is the sole responsibility of the applicant/guardian
- Tuition is not tax deductible
- If attending with a Therapy Dog, please contact the National Office

2018 SPECIAL TOUCH SUMMER GET AWAY LOCATIONS

WISCONSIN • MAY 14-18

Spencer Lake Christian Center, Waupaca, WI
Coordinators: Talin & Rev. Cassie Scheuermann
Coordinators: Rev. Charlie & Debbie Chivers
715-258-2713

\$420 Full Tuition Due by: April 16

OKLAHOMA • MAY 21-25

New Life Ranch, Colcord, OK
Coord: Rev. Thomas & Rev. Angelia Carpenter
870-799-9656

\$450 Full Tuition Due by: April 23

FLORIDA • MAY 28-JUNE 1

Lake Aurora Christian Camp, Lake Wales, FL
Coordinators: Rev. Joe & Ann Trementozzi
321-543-8729

\$600 Full Tuition Due by: April 30

ILLINOIS • MAY 28-JUNE 1

Lake Williamson Christian Center
Carlinville, IL
Coordinator: Jonathan Spink
618-797-8232

\$460 Full Tuition Due by: April 30

KENTUCKY • JULY 23-27

Camp Crestwood, Crestwood, KY
Coordinator: Kusum Neal
502-227-2557

\$465 Full Tuition Due by: June 25

NORTH CAROLINA • AUGUST 6-10

Camp Dixie, Fayetteville, NC
Coordinators: Rev. Marshall & Gilda Wise
410-726-1769

\$455 Full Tuition Due by: July 9

GEORGIA • AUGUST 13-17

Camp Twin Lakes - Will-A-Way, Winder, GA
Coordinators: Rev. Joe & Ann Trementozzi
321-543-8729

\$400 Full Tuition Due by: July 16

OHIO • AUGUST 13-17

Heartland Conf. Retreat Center, Marengo, OH
Coordinators: Duane & Rev. Tracie Corll
330-507-9281

\$410 Full Tuition Due by: July 16

NORTH EAST REGION • AUG 21-25

Tuesday-Saturday
Eisner Camp, Great Barrington, MA
Coordinators: Rev. Mike & Rev. Kim Ferguson
978-400-6803

\$750 Full Tuition Due by: July 24

ARIZONA • SEPTEMBER 10-14

Lost Canyon, Williams, AZ
Coordinators: Rev. Frank & Jean Amico
928-530-4504

\$595 Full Tuition Due by: August 13



PO Box 25 • Waupaca, WI 54981
Nat'l Office 715-258-2713 • Fax 715-258-2777
www.specialtouch.org
centralprocessing@specialtouch.org

MAIL APPLICATION, DEPOSIT, MEDICAL RELEASES TO: **Special Touch Central Processing • PO Box 25 • Waupaca, WI 54981**

IF TUITION IS PAID ONLINE, FAX APPLICATION TO: **715-258-2777** OR EMAIL (FULL SIZE SCAN) TO: **centralprocessing@specialtouch.org**

Tuition Payment made online Date _____ Amount Paid \$ _____ Card Holder Name _____
Please allow one week for credit card processing

LOCATION(S) ATTENDING

PLEASE CHECK EACH GET AWAY THAT YOU ARE APPLYING AND SENDING DEPOSIT(S) FOR

A NON REFUNDABLE \$100 DEPOSIT MUST BE INCLUDED FOR EACH GET AWAY YOU ARE APPLYING FOR

<input type="checkbox"/> WISCONSIN May 14-18 \$420 Due April 16	<input type="checkbox"/> OKLAHOMA May 21-25 \$450 Due April 23	<input type="checkbox"/> FLORIDA May 28-June 1 \$600 Due April 30	<input type="checkbox"/> ILLINOIS May 28-June 1 \$460 Due April 30	<input type="checkbox"/> KENTUCKY July 23-27 \$465 Due June 25
<input type="checkbox"/> NORTH CAROLINA August 6-10 \$455 Due July 9	<input type="checkbox"/> GEORGIA August 13-17 \$400 Due July 16	<input type="checkbox"/> OHIO August 13-17 \$410 Due July 16	<input type="checkbox"/> NORTH EAST REGION Aug 21-25 \$750 Due July 24 <i>Tuesday-Saturday</i>	<input type="checkbox"/> ARIZONA September 10-14 \$595 Due August 13

I need an Invoice to be included (*Invoices are for tuitions paid by 3rd parties, Guest is responsible to have tuition paid in full by Due Date*)

APPLICANT INFORMATION

PLEASE PRINT CLEARLY *Incomplete applications cannot be processed until complete*

Applicant Name _____ Preferred Name _____
First Last (If different from first name)

Address _____ City _____ State _____ Zip _____

Day Phone _____ Cell _____ Email _____

Male Female Height _____ Weight _____ Date of Birth ____/____/____ (*Under 10, attend with Guardian*) Age _____

Attending as Family Member

- A family member is a third person attending from the same family, staying in same room and not requiring an additional caregiver
- If attending as a family member skip to Guardian Signature on page 3 (*Under age 18 also requires completed Medical Form with Physician's Signature*)
- Tuition for family member is 25% off the full tuition price – \$100 is still applicable

Live in own home/apt Foster Home CBRF/AFH Residential Facility/Group Home Name _____

Has applicant attended a Get Away before? No Yes # of times _____ Last Year Attended _____ Location _____

Do you actively attend an Official Special Touch Chapter? No Yes If Yes, what location? _____

Applicant's Home Church _____ City _____

GUARDIAN INFORMATION

I am my own Guardian - *Skip to Emergency Information*

Name of Legal Guardian _____ Relationship to Applicant _____

Address _____ City _____ State _____ Zip _____

Day Phone _____ Cell _____ Email _____

EMERGENCY INFORMATION

Emergency Contact - *If legal guardian is unavailable, notify:* Name _____

Relationship to Applicant _____ Day Phone _____ Cell _____

OFFICE USE ONLY				CG _____ Room _____
Payer <input type="checkbox"/> Self <input type="checkbox"/> Other _____	Check # _____	\$ _____		Co CG _____ CIT _____
<input type="checkbox"/> Guardian <input type="checkbox"/> Med Form	Allergies/Intolerance: <input type="checkbox"/> None <input type="checkbox"/> Food <input type="checkbox"/> Med <input type="checkbox"/> Other			TL _____ Med Staff _____
Disability: <input type="checkbox"/> IN <input type="checkbox"/> IN/PH <input type="checkbox"/> PH	Wheelchair: M E Other: _____			Chapel: Green H Green Yellow <input type="checkbox"/> Therapy Dog
<input type="checkbox"/> Bringing Therapy Dog	<input type="checkbox"/> Received Therapy Dog Registration Form			

DISABILITY CLASSIFICATION

PHYSICAL DISABILITIES

CHECK ALL APPLICABLE BOXES FOR PHYSICAL DISABILITIES

DIAGNOSIS

- | | |
|--|---|
| <input type="checkbox"/> Brain Trauma | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> Spinal Cord Injury |
| <input type="checkbox"/> Other - explain _____ | |

OTHER FACTORS

- | | |
|--|---|
| <input type="checkbox"/> Uses Wheelchair/Scooter | <input type="checkbox"/> Non-Verbal |
| <input type="checkbox"/> Uses Walker | <input type="checkbox"/> Blind |
| <input type="checkbox"/> Uses Sign Language | <input type="checkbox"/> Sight Impaired |
| <input type="checkbox"/> Hearing-Impaired | <input type="checkbox"/> Deaf |
| <input type="checkbox"/> Uses Hearing Aides | <input type="checkbox"/> Wears Glasses |
| <input type="checkbox"/> Will bring Service Dog
Call for Canine Registration Form | |

Other - explain _____

SELF HELP AND SUPERVISION NEEDED

- Lives Independently - No assistance needed
- Will require assistance from Special Touch Staff
- | | | |
|----------------------------------|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> Minimal | <input type="checkbox"/> Moderate | <input type="checkbox"/> Individual |
|----------------------------------|-----------------------------------|-------------------------------------|

INTELLECTUAL DISABILITIES

CHECK ALL APPLICABLE BOXES FOR INTELLECTUAL DISABILITIES

CARE LEVEL NEEDED

- High Functioning Intellectual Disability (*Guidance needed*)
- Mild Intellectual Disability (*Minimal Assistance needed*)
- Moderate Intellectual Disability (*Extensive Assistance needed*)
- *Severe/Profound Intellectual Disability (*Totally dependent*)
- *Get Away is not designed for people with Severe/Profound Disabilities*

OTHER FACTORS

- | | |
|---|--|
| <input type="checkbox"/> Uses Sign Language | <input type="checkbox"/> Down Syndrome |
| <input type="checkbox"/> Non-Verbal | <input type="checkbox"/> Autistic Behavior |
| <input type="checkbox"/> Deaf | <input type="checkbox"/> Sight Impaired |
| <input type="checkbox"/> Hearing-Impaired | <input type="checkbox"/> Wears Glasses |
| <input type="checkbox"/> Uses Hearing Aides | <input type="checkbox"/> Blind |

Other - explain _____

SELF HELP AND SUPERVISION NEEDED

- Lives Independently
- Needs minimal supervision
- Requires individual staff supervision due to:
- | | |
|-------------------------------------|---|
| <input type="checkbox"/> Care Needs | <input type="checkbox"/> Intellectual Level |
|-------------------------------------|---|

PROVIDING MY OWN CAREGIVER*

Fill in information for caregiver the applicant is providing.

Relationship to applicant

- Mother Father

Gender Male**

Female**

Family Member

Personal Assistant

Name * ** _____

City _____

State _____

Zip _____

**Caregiver's completed Special Touch Staff Application must be submitted with this application. **Unless related, caregiver must be of same sex as applicant.*

SKILL EVALUATION

Check the most appropriate statements in each category

MOBILITY *Please bring your own equipment*

- Walks Alone Needs Assistance Cannot Walk
- Walks Slow Medium Fast
- Can climb stairs Cannot climb stairs
- Uses and will **BRING** Walker Braces Cane Scooter
- Electric Wheelchair Manual Wheelchair
- Can manipulate wheelchair alone
- Cannot manipulate wheelchair alone
- Paraplegic Quadriplegic

TRANSFERRING

- Transfers Alone Bears own weight
- Pivot transfers with caregiver Uses Mechanical Lift
- (If unable to pivot transfer or bear own weight, mechanical lift WILL be used)*

PERSONAL HYGIENE/DRESSING/SLEEPING

- Independent – Needs no assistance
- Needs prompts, but can care for self
- Is slow, but can care for self
- Needs assistance with
- | | |
|---|--|
| <input type="checkbox"/> Showering | <input type="checkbox"/> Water temperature |
| <input type="checkbox"/> Helmet | <input type="checkbox"/> Washing hair |
| <input type="checkbox"/> Drying Body | <input type="checkbox"/> Clothing |
| <input type="checkbox"/> Brushing Hair | <input type="checkbox"/> Brushing teeth |
| <input type="checkbox"/> Shoes | <input type="checkbox"/> Deodorant |
| <input type="checkbox"/> Shaving | <input type="checkbox"/> Glasses |
| <input type="checkbox"/> Braces/Splints | <input type="checkbox"/> Dentures |
- Totally dependent for all needs

Usual bedtime _____ Usually awakens at _____

- Bedrail Needed - Supplied by Guest
- Written instructions included. *Verbal instructions are inadequate.*

TOILET NEEDS *Send adequate supplies for needs*

- Independent – Needs no assistance
- Needs prompts, but can care for self
- Is slow, but can care for self
- Needs assistance with
- | | |
|---|--|
| <input type="checkbox"/> Clothing | <input type="checkbox"/> Wiping |
| <input type="checkbox"/> Uses Depends/Diapers | <input type="checkbox"/> Only at night |
| <input type="checkbox"/> At all times | <input type="checkbox"/> Incontinent |
| <input type="checkbox"/> Bowel | <input type="checkbox"/> Bladder |
| <input type="checkbox"/> Catheter | <input type="checkbox"/> Colostomy |
- Totally dependent for all toilet needs and transferring
- Female guest is able to care for self during menstruation:
- Fully Partially Not at all Expected during week N/A

EATING

- Independent – Needs no assistance
- Needs assistance with _____
- Dependent, must be fed (*Provide week supply of bibs*)
- Has difficulty swallowing solids liquids
- must use straw (*please send supply for week*)
- Requires pureed food - *Pureed food may NOT be available*
- Call Get Away Coordinator for clarification*
- Appetite large medium small limit helpings

ALLERGIC to foods listed _____

Diet restriction that CANNOT lapse during Get Away _____

(We are unable to provide specialized charting or diet for each applicant due to a camp type environment. If you cannot be tolerant in this area, YOU must provide special dietary foods i.e.: sugar free food and drink. Refrigeration and special preparation of food is NOT available. Call Get Away Coordinator for clarification.)

BEHAVIOR *Check all that apply*

- Generally happy Compliant Social Helpful
 Generally unhappy Cooperative Team Player
 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
 Poor Behavior - explain _____

Autistic Behavior - explain _____

Other Behaviors - explain _____

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 expectations and discipline at home. All instructions must be written.

COMMUNICATION *Check all that apply*

- No difficulty Has difficulty expressing self
 Understands directions & prompts Slow to communicate needs
 Difficulty understanding directions Uses gestures
 Non-verbal Uses own language board
 Uses sign language (Please attach a description of signs)

Comments _____

ACTIVITIES (*Not all Get Aways provide water activities*)

- Independent - Needs no assistance
 Needs assistance with Arts/Crafts Sporting/Recreation
 Dependent for all activities
Water Activities Not Allowed Afraid/Does not swim
 Allowed shallow Swims deep

Activities applicant enjoys _____

Cannot participate in _____

GUEST APPLICATION RELEASE

I give permission as legal guardian for the applicant to attend Special Touch Ministry, Inc. Summer Get Away. To the best of my knowledge, all signatures and information in the application is correct and the person herein described has my permission to engage in all activities, except as noted by myself and/or physician. I further understand that Special Touch Ministry, Inc. reserves the right to reject any applicant whose needs cannot be met by staff.

I understand that due to specific state laws and Special Touch Ministry policy, ALL medications, whether prescription or non-prescription, brought to Summer Get Away **MUST** be in **original container/prescription bottle, clearly marked with the name, dosage, frequency, times, and prescribing physician and not in pre-poured containers except for those pre-poured from a pharmacy if medication, prescribing physician and pharmacy are identified.** Applicant will not be allowed to stay if this is not followed.

In the event I cannot be reached in an EMERGENCY, I as a parent or as the legal guardian of the applicant, give permission to the Health Care Professional selected by the Summer Get Away staff to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for the applicant. I will assume financial responsibility for any medical treatment not covered by Special Touch Ministry, Inc. insurance.

If applicant displays inappropriate behavior, which causes dismissal, the legal guardian, or current home of the applicant assumes immediate responsibility for transportation and its cost to return applicant home. **NO REFUNDS WILL BE GIVEN.** I agree not to send applicant if exposed to a contagious disease within three weeks of the event, and I will notify Special Touch Ministry, Inc. if applicant must cancel. No one will be denied attendance at Special Touch Summer Get Away because of religion, creed, national origin, sex, age, or disability.

I release and hold harmless Special Touch Ministry, Inc. its board of directors, staff, leadership, and volunteers, from liability due to negligence by Special Touch Ministry, Inc. staff or volunteers. I shall bring no claims, demands, or litigation against Special Touch Ministry, Inc. for losses due to bodily injury, death, or property damage arising out of or related to participation at Special Touch Summer Get Away. I further understand and agree that if a dispute arises between the applicant or legal guardian and Special Touch Ministry, Inc, that I as parent or legal guardian on behalf of applicant agrees to binding mediation or arbitration, foregoing any right I may have to bring action in a court of law. The laws of the state will govern any dispute.

I understand that certain physical and emotional risks are inherent in participating in any recreational camp activity including Special Touch Ministry Summer Get Away. These risks include but are not limited to (1) loss or damage of personal property; (2) injury or fatality due to and/or related to (a) walking, running, jumping, swimming, sports participation, or other

physical activity (b) head, neck, arm, leg, and/or back injuries (c) exposure to inclement weather, outdoor terrain, and all risks inherent therein (d) slips and falls, and (e) any and all other aspects and stress related to participating in Special Touch Summer Get Away. I release and hold harmless Special Touch Ministry, Inc. its board of directors, staff, leadership, and volunteers, from liability due to negligence by Special Touch Ministry, Inc. staff or volunteers.

I understand the willful and wrongful dissemination of any confidential or copyrighted material owned in its entirety, in part, in development, or held in confidence by Special Touch Ministry, Inc., in any format including but not limited to; electronic, print, or video, by Special Touch Ministry, Inc., or its affiliates, to any person, any organization, or any entity, religious or non-religious, will subject the individual to any and all civil and criminal penalties applicable under federal and state law.

I agree that if any portion of this document is deemed to be partially void, invalid, or unenforceable, that provision shall continue in full force and effect to maximum extent permitted by law, without affect to any other remaining provisions of this document which shall continue in full force and effect. To the extent that any provision of this document is deemed completely void, invalid, or unenforceable, that provision shall be severed from the remainder of this document and all remaining provisions of this document shall continue in full force and effect.

I understand that individuals are prohibited from carrying any weapon, as defined by state and local law, and including, but not limited to; handguns, firearms, "electric weapons" identified as any device which is used or intended to be used to immobilize or incapacitate persons by the use of electric current, a knife, a Billy club, or any other implement that is fashioned, designed, or intended to be used as a weapon, at any Special Touch Ministry events. I also realize that tobacco, electronic cigarettes, alcohol and drugs (except those administered by Medical Staff) are not allowed at Special Touch events. **NO SMOKING/VAPING ALLOWED.**

Permission is given to Special Touch Ministry, Inc. to use photographs (individual or group) and/or multi-media images and recordings made or obtained from any official Special Touch Ministry, Inc. event including but not limited to; fundraising events, Chapter meetings, speaking engagements, etc. I understand that photographs/video/images taken by individuals at a Special Touch function are for personal use only and that Internet use of this media should be approached with caution due to liability of misrepresentation.

The information contained in this application is correct, to the best of my knowledge. I have read, understand, and agree to the above statement and agree with the aforementioned terms and conditions subject to attending a Special Touch Summer Get Away. I understand my e-mail address will be added to Special Touch Ministry's contacts and I may request removal.

PRINT Name of Legal Guardian: _____ **Contact Phone:** _____

SIGNATURE of Legal Guardian or Applicant if own legal guardian: _____ **Date:** _____

(Applications will not be processed without proper signatures)

A CONFIRMATION OF ACCEPTANCE WILL BE SENT NO LATER THAN TWO WEEKS PRIOR TO THE SUMMER GET AWAY.

ALL INFORMATION IS KEPT PRIVATE AND CONFIDENTIAL AND IS INTENDED SOLELY FOR THE USE OF SPECIAL TOUCH MINISTRY, INC.

MEDICAL RELEASE FORM
Substitutions of this form will not be accepted

All applicants must have a medical examination within twelve months prior to date of Get Away applying for.

Applicant's Name _____ City _____ State _____

Date of Birth ____/____/____ Height ____ft ____in Weight _____lbs Blood Pressure ____/____

Medical diagnosis of disability _____

Explanation/Onset/Cause of disability _____

Applicant's current health condition _____

Activities applicant should not participate in _____

Operations/Serious Illness (include Dates & Description) _____

Chronic/Recurring Illness _____

Applicant has seizures No Yes - Frequency _____ Date of last seizure _____ Controlled by medication _____

Describe seizure _____

DISEASES/PAST ILLNESS

- Diabetes
- Asthma
- Chicken Pox
- Tuberculosis
- Other _____

ALLERGIES

- Penicillin
- Aspirin
- Latex
- Hay Fever
- Food _____
- Other _____

IMMUNIZATIONS *Enter month & year of each immunization*

- HEP A Date 1 _____ Date 2 _____
- HEP B Date 1 _____ Date 2 _____ Date 3 _____
- HIB Date 1 _____ Date 2 _____ Date 3 _____
- DPT/DT/TD Date 1 _____ Date 2 _____ Date 3 _____ Date 4 _____ Date 5 _____
- Polio/IPV Date 1 _____ Date 2 _____ Date 3 _____ Date 4 _____ Date 5 _____
- MMR/MMRV Date 1 _____ Date 2 _____ Date 3 _____ Date 4 _____ Date 5 _____

MEDICATION *Pre-packaged from Pharmacy accepted - Please list additional medications on separate page*
ALL MEDICATIONS MUST BE IN ORIGINAL PRESCRIPTION BOTTLE MARKED FOR CONTENT, DOSAGE, AND FREQUENCY

Medication Name	Dosage
<i>Example: Dilantin chewable</i>	<i>two 50mg tablets</i>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Adverse reactions from medications _____

PHYSICIAN PERMISSION

I have examined the person herein described and have reviewed their health history. It is my opinion that they are physically able to engage in Special Touch Ministry Inc. functions through the end of the calendar year, except as noted above.

Physician's Name _____

Physician's Signature _____ Date _____
RN, LPN, QMRP signatures are NOT acceptable

Clinic Name _____ Phone _____

Address _____ City _____ State _____ Zip _____