Special Journeys, LLC
Trip Signup Form

Traveler's Name _____

City and State _____

Step 1: Select Your Trip

Please write in the name of the trip(s) that you are signing up for: _____

_____

Spend Down or Pre-Payment: I want to pre-pay for a trip that will be selected later _____

Step 2: Trip Insurance (OPTIONAL)

For international vacations and cruises you may want to consider purchasing trip insurance (cost ranges from 5 to 15% of the total trip cost). We recommend contacting Travel Safe Insurance and selecting their Cancel For Any Reason option (www.travelsafe.com or 888-885-7233). To waive pre-existing conditions with Travel Safe you must purchase trip insurance within 14 days of trip signup. Please note that as part of *Your Guaranteed Cost Trip*™ we automatically cover costs associated with weather and travel delays and missed flight connections for all travelers.

Step 3: Additional Staffing Needs (OPTIONAL)

One-on-one staff needed for this traveler (additional expense required) _____

Name of the staff you will be sending with the traveler _____
(Note: A separate volunteer application must be completed for this person)

Step 4: Payment Information (Please select one)

_____ Hold a space for 10 days (deposit or payment required after 10 days)

_____ Deposit Included ($100 for Bus or $200 for Air, Cruise or International Vacations)

_____ Partial Payment of _____ enclosed

_____ Full Payment enclosed

Step 5: Application (Please select one)

Application Enclosed _____

Application Already On File (No need to resend unless there are changes! If there are changes only complete the page(s) covering the relevant change(s)) _____

Special Journeys, LLC
PO Box 30256, Omaha, NE 68103
Kansas City Office Phone: (913) 227-0044 Omaha Office Phone: (402) 884-1014
Fax: (877) 934-8832 www.specialjourneys.org

Traveler Application

Full Legal Name (incl. Middle Initial) _____

Traveler's Common First Name: _____

Street Address: _____

City: _____ State: IA KS MO NE SD Zip Code: _____

Phone Number: (Day) _____ (Evening) _____

Date of birth: _____/_____/_____ Gender: Male / Female

Does Traveler have a: State Issued Photo ID? Yes / No
Passport? Yes / No

T-Shirt/Sweatshirt Size: XXXL XXL XL L M S

Agency Name: _____

Contact Person: _____

Full Address: _____

Phone: (Day) _____ (Evening) _____

Fax: _____ E-mail address: _____

Parent/Guardian Name: _____ Relationship: _____

Full Address: _____

Phone: (Day) _____ (Evening) _____

1st Emergency Contact: _____ Relationship: _____

Phone: (Day) _____ (Evening) _____

2nd Emergency Contact: _____ Relationship: _____

Phone: (Day) _____ (Evening) _____

Correspondence (receipts & trip information) should be sent to:

Agency Contact _____ Traveler _____ Guardian _____ Other (specify) _____

Part 2: Traveler information

____ Developmentally Disabled

_____ Mild _____ Moderate _____ Severe _____ Profound

____ Physically Disabled

____ Blind ____ Hearing impaired ____ Non-verbal ____ Mobility Issues

Does the traveler have a history of seizures? Yes _____ NO ____ If YES, and a seizure has occurred in the last two (2) years please complete the form "*Additional Information for Travelers with Seizures*"

Does the traveler have insulin controlled diabetes? Yes _____ NO ____ If YES, please complete the form "*Additional Information for Travelers with Insulin Controlled Diabetes"*

Can the traveler walk two or three blocks without any assistance? Yes _____ NO ____ If NO, please complete the form *"Additional Information for Travelers with Mobility Issues"*

If the traveler is bringing any mobility equipment or has any specific vehicle needs please complete the form *"Additional Information for Travelers with Mobility Issues"*

Please check all that apply:

_____ Wears glasses	_____ Visually impaired	_____ Asthma
_____ Contact lenses	_____ Poor coordination	_____ Stroke
_____ Hearing aid	_____ Arthritis	_____ Prader-Willi Syndrome
_____ Dentures	_____ Tires Easily	_____ Psychological Impairment
_____ Smokes	_____ Wanders *(please describe <u>fully</u> below)*	_____ Heart condition (describe fully below)
_____ Seasonal Allergies	_____ Irregular sleeping (describe below)	_____ Diabetes (controlled w/o Insulin)
_____ Uses sign language	_____ Needs more than 1:4 or 1:3 staff level (describe below)	_____ Special Diet (describe below)
_____ Swimmer	_____ Sleep walking	_____ Food Allergies

Please describe each item checked above:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Is traveler self-medicating with prescription medication on vacation? Yes / No

Can traveler take:	Aspirin Yes / No	Tylenol Yes / No	Advil Yes / No
Pepto-Bismol Yes / No	Imodium Yes / No	Milk of Magnesia Yes / No	
Tums Yes / No	Cough Syrup Yes / No	Decongestant Yes / No	

Describe all medication allergies: _____

_____

_____

Has traveler ever experienced motion sickness? YES/Unsure _____ NO ____ If YES/Unsure please complete the form "*Medi-Meclizine Authorization"*

Individual Information:

Toileting	_____ No Assistance	_____ Partial Assistance	_____Total Assistance
Showering	_____ No Assistance	_____ Partial Assistance	_____Total Assistance
Traveler requires:		_____ Roll-in shower	____ Shower grab bars
Dressing	_____ No Assistance	_____ Partial Assistance	_____Total Assistance
Eating	_____ No Assistance	_____ Partial Assistance	_____Total Assistance

Spending Money: _____ Traveler holds all money _____ Traveler holds money for each day, or _____ Staff holds all money and assists traveler.

Describe any information that will be helpful to care for the Traveler in reference to the above:

_____

_____

_____

_____

_____

_____

_____

_____

Traveler Likes: _____

Traveler Dislikes: _____

Traveler Fears: _____

Traveler's Special Skills: _____

What other trips would you be interested in that Special Journeys does not currently offer?

_____

The last time traveler went on a group vacation was: _____

Part 3: Behavior Information

Please indicate and describe in detail any behavioral concerns that may apply:

____ Injurious to self	____ Aggressive to others	
____ Verbally aggressive	____ Physically aggressive	____ Destructive to property
____ Interacts inappropriately with others	____ Inappropriate touch	____ Been sent home by another recreation provider
____ History of stealing	____ Fabricates stories	____ Needs constant supervision (1:1)

Please describe any behavioral concerns indicated above and how they are best handled:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Special Journeys LLC - Traveler Agreement and Release

Traveler's Name: _____

At Special Journeys, LLC we believe that everyone should have the opportunity to travel! As a result, we look forward to providing trips that explore new places in a structured manner.

As a traveler I acknowledge the enjoyment I receive from traveling. I understand that my experiences may involve activities, living arrangements and interactions that may be new to me, and that these experiences come with risks and uncertainties beyond what I may be used to dealing with every day. I realize that no environment is risk free and understand the importance of following the directions of the staff and volunteers.

In consideration of the services of Special Journeys, LLC, it's members, agents, volunteers, contractors, employees, and all other persons or entities acting in any capacity on their behalf (hereinafter collectively referred to as "Special Journeys"), I hereby agree to release and discharge Special Journeys, on behalf of myself, my children, my parents, heirs, assigns, personal representatives and estate as follows:

(1) I acknowledge that the trips entail both known and unknown risks which could result in illness, aggravation of an existing illness or condition, disease, physical injury, emotional injury, permanent disability, death, or damage to me, to property, or to third parties. I understand that staff and volunteers are responsible for their own care as well as for the care of other travelers and that they may not be able to provide me with constant supervision.

(2) I hereby voluntarily release, waive, covenant not to sue, forever discharge and agree to indemnify and hold harmless Special Journeys from any and all liabilities, claims, demands, actions or causes of action whatsoever which are in any way connected with my participation in the trip and in transit to or from the trip, including any such claims which allege negligent acts or omissions of Special Journeys, to the fullest extent permitted by law.

(3) Should Special Journeys be required to incur attorney's fees and costs to enforce this agreement, I agree to indemnify and hold them harmless for all such fees and costs.

(4) I certify that I have adequate insurance to cover any injury or damage I may cause or suffer while traveling, or else I agree to bear the costs of such injury or damage myself. I further certify that I have no medical or physical conditions which could interfere with my safety on this trip, or else I am willing to assume, and bear the costs of, all risks that may be created, directly or indirectly, by such condition.

(5) I agree that if any portion of this agreement is held to be invalid by a court of law then it is agreed and intended that all the remainder shall, notwithstanding, continue in full force and effect.

(6) In the event that I sue Special Journeys, I agree the venue of any dispute arising from this agreement or otherwise between the parties to which Special Journeys is a party shall be Douglas County, Nebraska. I also agree that the substantive law of Nebraska shall apply in that action without regard to the conflict of law rules in Nebraska.

TRAVELER OR THEIR GUARDIAN HAS CAREFULLY READ THESE TERMS AND FULLY UNDERSTANDS THEIR CONTENT AND IS AWARE THAT THIS IS A RELEASE OF LIABILITY, EVEN IF ARISING FROM THE NEGLIGENCE OF SPECIAL JOURNEYS, AND A CONTRACT BETWEEN TRAVELER OR THEIR GUARDIAN AND SPECIAL JOURNEYS AND SIGNS OF HIS OR HER OWN FREE WILL.

Date: _____ ***Both traveler and legal guardian should sign unless traveler is his/her own guardian.***

Traveler's Signature: _____ Guardian's Signature: _____

Printed Name: _____ Printed Name: _____

Medical Emergency & Photo Release

Medical Emergency

In case of a medical emergency, I understand that every reasonable effort will be made to contact the emergency contact(s) listed on the application. In the event that my contact(s) cannot be reached, or if Special Journeys, the attending physician and/or the health care provider believes that immediate care without delay is required or appropriate, I hereby give permission to the physician or health care provider selected by Special Journeys to secure medical treatment, hospitalization and/or anesthesia and, in addition, I hereby consent to injection, surgery and/or medication.

Traveler's Signature: _____ Guardian's Signature: _____

Printed Name: _____ Printed Name: _____

Photo Release

I consent to the use of my image by Special Journeys for any and all purposes, including without limitation video, still photographs, publication, and any trade or advertising purposes, provided such uses are not made so as to constitute a direct endorsement of services.

Traveler's Signature: _____ Guardian's Signature: _____

Cancellation Policy

I agree to the cancellation notice policy listed below:

Motorcoach Tours
- Any time before the trip signup deadline – full refund
- On or after the trip signup deadline - $100 deposit retained plus any monies Special Journeys is unable to get refunded from our suppliers.
- Multiple cancellations may cause a custom cancellation policy to apply to a specific traveler.

Air, Rail, Cruise, and International Tours
- Any time before the trip signup deadline - full refund
- On or after the trip signup deadline - 20% of total trip fee retained plus any monies Special Journeys is unable to get refunded. Airfare and cruise cabins are non-refundable costs.
- Multiple cancellations may cause a custom cancellation policy to apply to a specific traveler.

Late & No-Show Travelers
- No-shows on the day of departure receive no refund whatsoever
- Travelers who are late for departure are considered no shows

Traveler's Signature: _____ Guardian's Signature: _____

Additional Information for Travelers with Seizures

Please complete this form if the traveler has a history of seizures and a seizure has occurred in the last two (2) years.

Traveler's Name _____ City and State _____

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers, warning signs and/or behavior changes prior to seizures: _____

_____

Traveler's reaction to seizure: _____

Usual time of day seizure occurs (if any): _____

Average length of time until traveler can return to regular activities: _____

Basic Seizure First Aid

- ✓ Stay calm & track time
- ✓ Keep traveler safe
- ✓ Do not restrain
- ✓ Do not put anything in mouth
- ✓ Stay with traveler until fully conscious
- ✓ Record seizure in log

For grand mal seizure

- ✓ Protect head
- ✓ Keep airway open / watch breathing
- ✓ Turn traveler on side

A Seizure is generally considered an Emergency when:

- ✓ A convulsive (grand mal) seizure lasts longer than five (5) minutes
- ✓ Traveler has repeated seizures without regaining consciousness
- ✓ Traveler has a first time seizure
- ✓ Traveler is injured or has diabetes
- ✓ Traveler has breathing difficulties
- ✓ Traveler has a seizure in water

Seizure Medication and Treatment Information

Does the traveler take emergency/rescue medication? Yes _____ No _____

Medication	Dosage	Administration Instructions (timing *1 & method *2)	What to do after administration

*1 – After 2nd or 3rd seizure, for cluster of seizures, etc *2 – Orally, under tongue, etc.

Should any of these medications be administrated in a special way? YES _____ NO _____

If YES, please explain _____

Should any particular reaction be watched for? YES _____ NO _____

If YES, please explain _____

Does the traveler have a Vagus Nerve Stimulator (VNS)? YES _____ NO _____

If YES, please describe instructions for appropriate magnet use: _____

_____

Please list any other information that would be helpful for our staff to know regarding this traveler and seizures: _____

_____

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- ✓ Stay calm & track time
- ✓ Keep traveler safe
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- ✓ Do not put anything in mouth
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- ✓ Traveler has a first time seizure
- ✓ Traveler is injured or has diabetes
- ✓ Traveler has breathing difficulties
- ✓ Traveler has a seizure in water

Additional Information for Travelers with Insulin Controlled Diabetes

Please complete this form if the traveler has insulin controlled diabetes.

Traveler's Name _____ City and State _____

Exact name and brand of insulin used: Short acting: _____

Long acting (time & dose): _____

The insulin is delivered via: Pen _____ Syringe _____

Is insulin coverage for lunch taken _____ BEFORE or _____ AFTER the meal?

Target blood glucose: Pre-Meal: _____mg/dl; 2 hours after meals: _____ mg/dl

Insulin Coverage for: Meals, Snacks & Long Acting Insulin

Meal/Snack	Time	Insulin: Carb ratio	Carb grams per meal	Type of insulin	Units of insulin	Is sliding scale present?
AM						☐ Yes ☐ No
Breakfast						☐ Yes ☐ No
AM Snack						☐ Yes ☐ No
Lunch						☐ Yes ☐ No
PM Snack						☐ Yes ☐ No
Dinner						☐ Yes ☐ No
Bedtime						☐ Yes ☐ No
Night						☐ Yes ☐ No

Sliding Scale

Sliding Scale: The amount of insulin used to cover an elevated blood glucose **over** the amount of insulin used to cover meals.

Correction Factor (Blood Glucose – Target) ÷ Sensitivity
Formula (if used) (Blood Glucose - _____ ÷ _____

If Blood Glucose is less than _____ mg/dl = Give **NO Sliding Scale Insulin**

Blood Glucose _____ to _____ mg/dl give _____ Units

Blood Glucose _____ to _____ mg/dl give _____ Units

Blood Glucose _____ to _____ mg/dl give _____ Units

Blood Glucose _____ to _____ mg/dl give _____ Units

Blood Glucose _____ to _____ mg/dl give _____ Units

Blood Glucose above _____ mg/dl give _____ Units

Additional Information for Travelers with Mobility Issues

Please complete this form if the traveler is unable to walk two or three blocks without any assistance; is bringing mobility equipment or has any special vehicle needs.

Traveler's Name _____

City and State _____

Height: _____

Weight: _____

Traveler will bring:

____ Electric Wheelchair
____ Manual Wheelchair
____ Travel Wheelchair
____ Walker
____ Gait Belt
____ Hoyer Lift
____ Cane
____ Adaptive eating device (please describe)
____ Toilet/Shower Chair
____ Leg Braces
____ Other (please describe)

PLEASE CLEARLY LABEL ALL EQUIPMENT WITH TRAVELER'S NAME

Pickup and Drop Off Vehicle Requirements:

____ Traveler must be transported in a wheelchair van
____ Traveler can be transported in a car
____ Traveler can be transported in a minivan
____ Traveler can be transported in 15 passenger van (step stool always used)
_____ Front seat **only** in 15 passenger van

On a full sized charter bus:

____ Traveler needs a wheelchair lift to enter
____ Traveler may need wheelchair lift to enter during the course of the trip (describe fully)
____ Traveler can use stairs with assistance
____ Traveler must remain in wheelchair for duration of bus ride
____ Traveler can transfer from wheelchair to a seat on the bus and is able to sit independently
____ Traveler can transfer from wheelchair to a seat on the bus and needs staff by their side

Wheelchair Usage:

____ Traveler does not use a wheelchair. **Please complete next question only**
____ Traveler uses a wheelchair full time **Please complete page 2**
____ Traveler uses a wheelchair for long distances **Please complete page 2**

Walking Assistance Needed:

____ Traveler requires assistance walking over uneven ground, on stairs and over difficult terrain
____ Traveler requires physical assistance of staff while walking at all times

Describe walking assistance needed: _____

_____

Travelers Who Use a Wheelchair

Traveler's ability in a wheelchair:

____ In a manual wheelchair, traveler can move independently without being pushed

____ In a manual wheelchair, traveler must be pushed at all times

____ In a manual wheelchair, traveler needs assistance during certain times, such as when going uphill

____ Traveler uses a manual wheelchair for long distances or when tired (please describe)

____ In an electric wheelchair traveler can move independently

____ In an electric wheelchair traveler needs assistance

Transfer Information

____ Traveler transfers self

____ Traveler can bear weight

____ Traveler needs partial assistance to transfer (please fully describe)

____ Traveler needs total assistance with transferring

Transfer Method

The traveler requires the following transferring technique:

____ Stand Pivot ____ Two person lift ____ Hoyer Lift

Please describe any information regarding transfers that would be helpful for our staff to know:

_____

_____

_____

_____

Medi-Meclizine Authorization

Please complete this form if the traveler has a history of motion sickness or to authorize this OTC medicine if motion sickness arises.

Traveler's Name _____ City and State _____

We do not encounter motion sickness on a regular basis with travelers. Our tour leaders are fully trained on the best practices to deal with this issue. However, when it arises it can make an individual traveler's vacation an unpleasant experience.

When a traveler needs medicine to deal with motion sickness our preferred option is Meclizine Hydrochloride. Your tour leader will have this OTC medicine available and packaged as Medi-Meclizine or Bonine.

Do not take unless directed by a doctor if you:

- have glaucoma
- have trouble urinating due to an enlarged prostate gland
- have a breathing problem such as emphysema or chronic bronchitis
- are taking sedatives or tranquilizers
- are pregnant

Please check yes or no regarding this over the counter medicine:

___ YES, I can take Meclizine Hydrochloride.

___ NO, I cannot take Meclizine Hydrochloride.

If you have any questions please feel free to contact us at (402) 884-1014 or (913) 227-0044.