



Special Journeys, LLC - PO Box 30256, Omaha, NE 68103
E-Submit via: Fax: (877) 934-8832 or scan to info@specialjourneys.org

Traveler Application

Full Legal Name for ticketing (incl. Middle Initial): _____

Traveler's Common First Name (for nametag): _____

Date of birth: ____/____/____ Gender: ___ Male ___ Female

Traveler has: State-Issued Photo ID? ___ Yes ___ No
Passport? ___ Yes ___ No

T-Shirt/Sweatshirt Size: ___ 3XL ___ 2XL ___ XL ___ L ___ M ___ S

Agency Name: _____

Contact Person: _____

Full Address: _____

Phone: (Day) _____ (Evening) _____

Fax: _____ E-mail address: _____

Living Arrangement: ___ Independent Living ___ Group Home
___ Family / Guardian ___ Host Home / Extended Family

Street Address: _____ Apt # _____
(Please include full address, including street direction and street type/suffix)

City: _____ State: _____ Zip Code: _____

Phone Number: (Day) _____ (Evening) _____

Fax: _____ Traveler E-mail address: _____

Home Provider Name (if applicable): _____

E-mail address: _____

Payee Service (if applicable, name only): _____

E-mail address: _____

Parent/Guardian Name: _____ **Relationship:** _____

Full Address: _____

Phone: (Day) _____ (Evening) _____

E-mail address: _____

Communication

Pre-Trip Information:

Mark up to four individuals who should receive pre-trip information via e-mail and fax.

<input type="checkbox"/> Traveler	<input type="checkbox"/> Agency Contact	<input type="checkbox"/> Other Residential Staff
<input type="checkbox"/> Host Home/Extended Family Provider	<input type="checkbox"/> Guardian	<input type="checkbox"/> Group Home Manager

Other (specify) _____

Receipts via E-mail:

Mark the individuals who should receive e-mails with receipts for all payments sent in. If you have a Payee they must receive a copy!

<input type="checkbox"/> Traveler	<input type="checkbox"/> Agency Contact	<input type="checkbox"/> Payee
<input type="checkbox"/> Host Home/Extended Family Provider	<input type="checkbox"/> Guardian/Parent	

Receipts via Mail: Please assist us in getting receipts to you in a timely manner via e-mail. If you have no other method of receiving receipts we will send copies to up to two addresses. Please enter the individuals who should receive mailed receipts:

Additional E-mail Address: If the e-mail address of any of the above is NOT on page 1, enter it here:

Traveler Disabilities

Intellectual Disability

Mild Moderate Severe Profound

Developmental Disability

Cerebral Palsy Autism Downs Syndrome
 Traumatic Brain Injury Petit Mal Seizures
 Seizure history (2+ years ago) Current Grand Mal Seizures
(separate addendum required)

Mental Illness

Anxiety Bipolar Depression
 Psychological Impairment

Physical Disability

Blind Deaf Hearing Impaired
 Non-verbal Mobility Issues *(addendum required)*

Traveler Cares

Mark all that apply and provide a full description. **Application will NOT be accepted without a full description.**

Dentures Hearing Aid Smoker/Chews Tobacco

Medical Issues (mark all that apply)

No Medical Issues
 Arthritis Seasonal allergies Pre-Diabetes
 Stroke Asthma Diabetes (no insulin)
 Heart Condition Constipation Diabetes (uses insulin)
(addendum required)

FULLY describe marked items below:

Food & Eating Issues (mark all that apply)

- No Food Issues
- Food Intolerances *Separate Addendum required*
- Significant Food Dislikes
- Food Allergies *Separate Addendum required*
- Special Diet (e.g. low calorie, no fried foods)

Eating Assistance Needed:

- Monitor for choking
- Eats too fast
- Portion controls
- Eats too slow
- Total Assistance

Needs Food Cut Up:

- General cutting
- Cut meat bite sized
- Cut All Food bite sized
- Additional solid/liquid food modification
Contact us for optional addendum

FULLY describe marked items below:

Walking Issues (mark all that apply)

- No Walking Issues
- Poor coordination
- Tires Easily
- Cannot walk 2 to 3 blocks

FULLY describe marked items below:

Spending Money (mark one)

Spending Money: Is held by traveler Must be held by staff

Prescription Medication (mark one)

Traveler: does not take any medicine.
 is self-medicating (handles medicine completely on their own).
 needs reminders only for taking medicine.
Note: Special Journeys must (a) be given meds at the pickup – not stored in suitcase, (b) hold meds during trip, and (c) have meds held only in our custom medicine bags.
 needs supervision for taking medicine.
Note: Special Journeys must (a) be given meds at the pickup – not stored in suitcase, (b) hold meds during trip, and (c) have meds held only in our custom medicine bags.

Over-The-Counter Medication (mark Yes or No for every item)

The traveler CAN take:

Aspirin Yes No Imodium Yes No
Advil Yes No Pepto-Bismol Yes No
Tylenol Yes No Milk of Magnesia Yes No
Decongestant Yes No Tums Yes No
Cough Syrup Yes No

Has traveler ever experienced motion sickness? Yes No Unsure

In the event of motion sickness, may we give the over-the-counter medicine Medi-Meclizine (same active ingredient as non-drowsy Dramamine)? Yes No

Medication allergies

Describe all medication allergies and type of reaction:

Assistance Needed (mark one in each category)

Toileting	<input type="checkbox"/> None	<input type="checkbox"/> Partial	<input type="checkbox"/> Total
Showering	<input type="checkbox"/> None	<input type="checkbox"/> Partial <input type="checkbox"/> Assistance with hair <input type="checkbox"/> General washing assistance	<input type="checkbox"/> Total
Specialty Shower Requirements	<input type="checkbox"/> None	<input type="checkbox"/> Wheelchair-Accessible Roll-in Shower	<input type="checkbox"/> Grab bars in tub (<i>see Note below</i>)
Dressing	<input type="checkbox"/> None	<input type="checkbox"/> Partial	<input type="checkbox"/> Total
Brushing Teeth	<input type="checkbox"/> None	<input type="checkbox"/> Partial	<input type="checkbox"/> Total
Shaving (males)	<input type="checkbox"/> No help needed		<input type="checkbox"/> Needs help
Hygiene products (females)	<input type="checkbox"/> No help needed		<input type="checkbox"/> Needs help

Hotel Tub Grab Bar Note: Grab bars in hotels are extremely limited and their design/placement varies greatly. If you select “grab bars” we will place a temporary adjustable clamp, 300 lb rated, shower bar on the tub.

Describe, in detail, any information that will be helpful to us in assisting the Traveler in the categories referenced above.

Behavior Issues

Mark all behavior issues that apply:

_____ No Behavior issues

Aggression

_____ Verbally

_____ Physically

_____ Aggressive gestures

_____ Harasses/teases others

_____ Resists supervision

Is aggressive toward:

_____ Other travelers (clients)

_____ Staff

_____ General public

_____ Self (self-injury)

_____ Property

Interactions

_____ Interacts inappropriately with others

_____ Fabricates stories

_____ Can become overly attached to others

Other

_____ History of stealing

_____ Wanders (please describe FULLY below)

_____ Irregular sleeping

_____ Been sent home by another recreation provider

_____ Legal obligations/issues

Describe in detail any behavioral concerns indicated above and how they are best handled:

1:1 Dedicated Staffing

Every night each Travel Companion assists in two hotel rooms containing 3 to 4 travelers. During the day we operate on a large group concept where Travel Companions assist any traveler who needs assistance. A Dedicated 1:1 Travel Companion is an optional staffing level.

_____ Mark here if a 1:1 Dedicated Travel Companion is required.

We are currently unable to provide Dedicated 1:1 Travel Companions - you will need to bring your own staff in these situations. **1:1 Travel Companions are an additional charge.**

Traveler Personality

To help provide an optimum travel experience, please tell us about the traveler's personality.

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: _____

Addendums for Specific Care Needs

Use the table below to determine the addendum(s) you need to include with your application.

Question:	If YES:	If NO:
1 Has the traveler had seizures in the last two years?	Complete Addendum A. Then go to question #2.	Go to question #2.
2 Does the traveler have insulin-controlled diabetes?	Complete Addendum B. Then go to question #3.	Go to question #3.
3 Does the traveler have mobility issues, need equipment, or need a special vehicle?	Complete Addendum C. Then go to question #4.	Go to question #4.
4 Does the traveler have food intolerances or food allergies?	Complete Addendum D. Then go to question #5.	Go to question #5.
5 Did you answer Yes to any of the questions above?	Complete the addendums, sign the release documents and submit application.	Sign the release documents and submit the application.

Addendum A

Travelers Who Have Had Seizures In the Last Two Years

Traveler's Name _____

City and State _____

Height: _____

Weight: _____

Seizure Information

Seizure Type	Length	Frequency	Description

How many seizures does the traveler average a month?: _____

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

Traveler's reaction to seizure: _____

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

Does the traveler fall during the seizure?: Yes No

 If Yes, have they been injured from the fall?: Yes No

 If Yes, do they wear protective clothing or helmet?: Yes No

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

Do you have an individualized seizure plan? Yes No

 If Yes, include it with your application.

**Continue to the second page
to complete the Medication and Treatment Section**

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 administered in a special way? Yes No

If YES, explain _____

Should any particular reaction be watched for? Yes No

If YES, explain _____

Does the traveler have a Vagus Nerve Stimulator (VNS)? Yes No

If YES, describe instructions for appropriate magnet use:

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

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

Addendum B

Travelers with Insulin-Controlled Diabetes

Traveler's Name _____

City and State _____

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

Long acting: _____

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						<input type="checkbox"/> Yes <input type="checkbox"/> No
Breakfast						<input type="checkbox"/> Yes <input type="checkbox"/> No
AM Snack						<input type="checkbox"/> Yes <input type="checkbox"/> No
Lunch						<input type="checkbox"/> Yes <input type="checkbox"/> No
PM Snack						<input type="checkbox"/> Yes <input type="checkbox"/> No
Dinner						<input type="checkbox"/> Yes <input type="checkbox"/> No
Bedtime						<input type="checkbox"/> Yes <input type="checkbox"/> No
Night						<input type="checkbox"/> Yes <input type="checkbox"/> 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

Addendum C

Travelers With Mobility Issues, Assistive Equipment and/or 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
(describe on page 2)

Toilet/Shower Chair

Leg Braces

Other (describe on page 2)

CLEARLY LABEL ALL EQUIPMENT WITH TRAVELER'S NAME
ENSURE THAT ALL EQUIPMENT IS WORKING PROPERLY PRIOR TO DEPARTURE

Pickup and Drop Off Vehicle Requirements:

Traveler must be transported in
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 bus

Traveler must remain in wheelchair for
entire bus ride

Traveler may need wheelchair lift to
enter during the trip (describe on
page 2)

Traveler can transfer from wheelchair to a
seat on the bus and can sit independently

Traveler can use stairs with
assistance

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. **Complete only
the next question.**

Traveler uses a
wheelchair full time. **Complete page 2.**

Traveler uses a wheelchair
for long distances. **Complete
page 2.**

Walking Assistance Needed:

Traveler needs assistance walking on
uneven ground, stairs, and difficult terrain

Traveler needs physical assistance
of staff while walking at all times

Describe walking assistance needed:

Travelers Who Use a Wheelchair

Traveler's ability in a wheelchair:

- | | |
|--|--|
| <input type="checkbox"/> In a manual wheelchair, traveler can move independently without being pushed | <input type="checkbox"/> In a manual wheelchair, traveler must be pushed at all times |
| <input type="checkbox"/> In a manual wheelchair, traveler needs assistance during certain times, such as when going uphill | <input type="checkbox"/> Traveler uses a manual wheelchair for long distances or when tired (describe below) |
| <input type="checkbox"/> In an electric wheelchair traveler can move independently | <input type="checkbox"/> In an electric wheelchair traveler needs assistance (describe below) |

Transfer Information:

- | | |
|---|--|
| <input type="checkbox"/> Traveler transfers self | <input type="checkbox"/> Traveler can bear weight |
| <input type="checkbox"/> Traveler needs partial assistance to transfer (fully describe below) | <input type="checkbox"/> Traveler needs total assistance with transferring |

Transfer Method:

- Can traveler assist with pivoting? Yes No
- Does the traveler use a pivot disk? Yes No
- Does the traveler use a transfer board? Yes No

The traveler requires the following transferring technique:

- Stand Pivot Two Person Lift Hoyer Lift

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

Additional information from Page 1:

Addendum D

Food Intolerances and Allergies

Traveler's Name

City and State

Food intolerances and allergies can have the similar symptoms of nausea, diarrhea, and/or vomiting, but they are very different in severity.

Food Intolerances: are generally not life threatening. They involve the digestive system (except Celiac which also involves the immune system). Symptoms may be delayed.

Food Allergies: can be life threatening. They involve the immune system. They can cause anaphylaxis, which requires epinephrine for treatment. Symptoms appear rapidly.

Important Information for our Travelers with Food Issues:

Our meals are prepared at restaurants that cook with allergens present throughout their kitchen. The risk of direct or cross-contamination - in the air, on equipment, and in food – is always a possibility.

If you have food issues, you should assume that there will be limited menu choices and that, depending on the severity of your issues, Special Journeys will defer to the chef to select whatever is safest for you. For this reason, you will be served with the tour leaders, last in line.

It is important to select a trip in which your food issues can be accommodated. Please feel free to contact us to discuss which trips may best match your needs.

Notice of Risks:

The Special Journeys team makes every attempt to identify ingredients that may cause reactions for those with food intolerances and allergies. We make every effort to instruct restaurant managers and/or food production staff on the severity of the food issues of our travelers.

However, there is always the risk of contamination. There is also a possibility that manufacturers of the commercial foods used in restaurants could change their formulation at any time, without notice. Furthermore, US law only requires food labeling to identify eight food allergens, so commercial foods can contain other allergens that are not listed on the label. Travelers concerned about food intolerances and allergies must be aware of these risks.

Special Journeys does not assume any liability for adverse reactions to foods consumed or items one may come into contact with while travelling with Special Journeys.

Food Intolerances

Mark the foods/drinks to which you are intolerant:

Dairy: Fluid Milk Butter Yogurt
 Cheese or items with cheese listed as an ingredient
 Baked Goods with any dairy listed as an ingredient
 Items with dairy or dairy-derivative ingredient (whey, lactose, casein, etc.)

Egg: Whole eggs (such as scrambled or hard-boiled eggs)
 Baked goods with any egg listed as an ingredient
 Other items with any egg listed as an ingredient

Wheat / Gluten: Items with any wheat/gluten listed as an ingredient

Fish or Shellfish: Fish Shellfish (most likely to be encounter on cruises)

Nuts: Peanuts Tree Nuts

Corn: Whole corn such as corn kernels, tortilla chips, corn muffins
 Items with corn or corn products listed as an ingredient

Soy: Soy Lecithin Soy Protein (concentrate, hydrolyzed, isolate)
 Items with soy listed as an ingredient

Other: List any other food intolerances, and indicate if the symptoms occur when the food is cooked, or fresh, or both. US law only requires food labeling to identify eight food allergens, so commercial foods can contain other allergens that are not listed on the label.

(Combined) Intolerance and Allergy Questions

- 1) How has your food issue been diagnosed (doctor, agency nurse, nutritionist)? How long have you had this issue?

- 2) Describe in detail what happens when you are exposed to the food?

- 3) How long does it take for symptoms to appear after you have been exposed to the food?

- 4) On a scale of 1 to 10, with 10 being the worst, how severe is your reaction to the food item? _____
- 5) How often in a month (for intolerance) or year (for allergy) do you have issues with the food?

- 6) Have you ever been hospitalized due to a reaction to this food? ___ Yes ___ No
- 7) Do you feel safe eating at most restaurants? ___ Yes ___ No
If "No", what restaurants do you feel safe patronizing?

If/when you eat at restaurants, what do you normally eat?

If/when you eat at restaurants, how do you make sure the food you eat is safe for you?

- 8) Is there any other information you would like to share with us to meet your food needs?

Food Allergies

If your food issue is an allergy, indicate in which cases you are likely to have an allergic reaction:

- 1) You ingest the food: Yes No
2) You touch the food: Yes No
3) The food is in close proximity: Yes No
Do you have asthma: Yes No

If you answered “Yes” to question 2 or 3 above, unfortunately Special Journeys is unable to safely accommodate you on our vacations.

Mark all items to which you are allergic:

Soy Wheat Milk Egg
 Fish Peanut Tree Nut Shellfish

Other: _____

Note: If you have selected “Other” please contact our office to ensure we can accommodate you. US law only requires food labelling for the eight most common allergens, so commercial foods can contain other allergens that are not listed on the label.

Required Attachments to this Addendum:

Attach to this addendum your individual *Food Allergy & Anaphylaxis Emergency Care Plan*, and ensure that the plan includes a recent photo of you. We also require a plan for on-trip storage of any epinephrine injector, antihistamine pills, and inhaler. To ensure that these crucial items will be immediately available in case they are needed, Special Journeys CANNOT store them in travelers' medicine bags with the other medications

Selecting A Food-Allergy-Safe Vacation:

We cannot emphasize enough the importance of working with our office to ensure that you select a trip that best matches with your allergy needs. In addition to allowing us to provide you with an enjoyable trip, this also allows us, whenever possible, to contact restaurants beforehand to pre-arrange allergy friendly meals. However, there are certain trips where this is difficult or impossible to arrange, so it is essential for you to consult with us before choosing a trip. Disney-related trips are a very good choice for travelers with food issues because Disney tracks the food carefully.