

**Accessible Recreational Travel Program
Health and Personal Information**

Traveler's Name: _____

**Please fill out the following as completely and thoroughly as possible.
Attach a separate piece of paper if necessary.**

Communication Skills:

Mobility Skills and Limitations (wheelchair, walker):

Behavioral Concerns (list all and be specific about techniques for addressing specific concerns):

Sleeping Habits (will be used to determine roommates/sleeping situations):
(Does the participant sleep through the night? What is their normal bedtime and wake-up time?)

Spatial Awareness (can traveler adapt to new locations i.e., find hotel room):

Bathing/Bathroom special needs: (Does the participant need assistance or reminders?) Note: If the individual is not independent in most aspects of this area, then a companion should accompany them.

Activity Likes and Dislikes:

Food Preferences:

Dietary Restrictions/ Allergies:

Medication Allergies, other Allergies:

Any Health Concerns or limitations on activities: (describe in detail, including seizures):

List Medications and Times:

Please detail any further information that you think will be beneficial to our staff:

Doctors Name: _____ Phone: _____

The following 2 questions are utilized for our United Way funding only, but are strictly voluntary

Estimated annual income of Camper: _____

Race/Ethnicity: (Please mark only one box)

<input type="checkbox"/> American Indian/Alaskan native	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian/Pacific Islander
<input type="checkbox"/> African American	<input type="checkbox"/> Multiple Races/ethnicities	<input type="checkbox"/> Caucasian/White
<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Other	<input type="checkbox"/> Unknown