



**Ventures Travel, LLC** \* 10509 108<sup>th</sup> Street NW; Annandale, MN 55302  
 Metro phone 952-852-0107 \* Toll free 866-692-7400 \* Fax: 952-852-0123  
 Email: [vt@venturestravel.org](mailto:vt@venturestravel.org) Website: [www.venturestravel.org](http://www.venturestravel.org)

All parts of the application and the Health History must be completed and mailed or faxed for registration in any Ventures Travel vacation. In order to assure the best possible experience, we need to have accurate information about each traveler, therefore, complete all items. Please include all personal information you feel may help us so we can provide a full, safe and happy vacation experience. Thank you.

**Please list trip number(s) and dates:** Date: \_\_\_\_\_

Trips desired: 1<sup>st</sup> choice: \_\_\_\_\_ 2<sup>nd</sup> choice: \_\_\_\_\_  
 3<sup>rd</sup> choice: \_\_\_\_\_ 4<sup>th</sup> choice: \_\_\_\_\_

Name \_\_\_\_\_  
 Last First Middle

Address \_\_\_\_\_  
 Street City State Zip

Telephone (\_\_\_\_) \_\_\_\_\_ County of Birth \_\_\_\_\_ County of Residence \_\_\_\_\_

Age \_\_\_\_ Date of Birth \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Email \_\_\_\_\_

**Check type of living situation:** Residential Facility\_\_\_\_ Foster Home\_\_\_\_ Nursing Home\_\_\_\_ SLS/SLA\_\_\_\_ SILS\_\_\_\_ Private Home\_\_\_\_  
 If applicant lives outside of private home, what is the staff/client ratio? 1:2\_\_\_\_ 1:3\_\_\_\_ 1:4\_\_\_\_ Other\_\_\_\_ If 1:1, explain below:

Residential Facility Name \_\_\_\_\_ Corporate Owner Name \_\_\_\_\_

Facility Contact Person \_\_\_\_\_ Facility telephone (\_\_\_\_) \_\_\_\_\_

Facility email (if different from above) \_\_\_\_\_

Fax # (\_\_\_\_) \_\_\_\_\_ Facility Cell phone: (\_\_\_\_) \_\_\_\_\_

**Important trip information will be sent out after application is received and traveler is registered for his/her vacation. This should be mailed to:** parent\_\_\_\_ group home staff\_\_\_\_ traveler\_\_\_\_ guardian\_\_\_\_ other: \_\_\_\_\_

Parent or Legal Guardian (circle one) name: \_\_\_\_\_

Phone number (\_\_\_\_) \_\_\_\_\_ Cell phone (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Their address \_\_\_\_\_  
 Street City State Zip

Place of employment (father) \_\_\_\_\_  
 Name of company Position/title

Work number: (\_\_\_\_) \_\_\_\_\_ Can be contacted at this number: Yes\_\_\_\_ No\_\_\_\_

Place of employment (mother) \_\_\_\_\_  
 Name of company Position/title

Work number: (\_\_\_\_) \_\_\_\_\_ Can be contacted at this number: Yes\_\_\_\_ No\_\_\_\_

Religious preference \_\_\_\_\_ Race: White\_\_\_\_ African-Am\_\_\_\_ Native-Am\_\_\_\_ Asian\_\_\_\_ Hispanic\_\_\_\_

Is this traveler a child of a veteran? Yes\_\_\_\_ No\_\_\_\_ Parent's Post # \_\_\_\_\_

Is traveler covered under Medicare or MA? Yes\_\_\_\_ No\_\_\_\_ MA/Medicare # \_\_\_\_\_

Does traveler have *any other or additional health* insurance coverage? If so, name company: \_\_\_\_\_

Policy # \_\_\_\_\_ Policy holder's name \_\_\_\_\_

**Emergency Contact Persons and/or Consultant: Please list two contacts who can be reached in the event of medical care or other issue.**

Name \_\_\_\_\_ Relationship to traveler \_\_\_\_\_

Home phone # (\_\_\_\_) \_\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Relationship to traveler \_\_\_\_\_

Home phone # (\_\_\_\_) \_\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_

**FOR OFFICE USE ONLY:** Application received \_\_\_\_\_ Deposit received \_\_\_\_\_ By \_\_\_\_\_  
 Record # \_\_\_\_\_ WC SLW 1:2 1:3 1:4 Other\_\_\_\_ 1:1 staff needed; PCA/volunteer going  
 Trips registered for: \_\_\_\_\_

**RELEASE FORMS:** Applicant Name \_\_\_\_\_

**Attendance Release:** I hereby give my permission for the applicant named above to participate in a supervised vacation through Ventures Travel, LLC (VT, LLC) signed through December 31 of same year. **I certify that the information on the application is true, accurate and complete.** VT, LLC emphasizes safety first; however participation in any vacation has inherent risks that may result in injury. I acknowledge and accept this fact and agree to hold harmless Ventures Travel, LLC, its employees, and agents.

**Emergency Release:** I hereby give permission to the non-medical travel staff selected by Ventures Travel, LLC to provide routine health care, administer prescribed and standing order medications, and if needed, seek emergency medical treatment including x-rays, routine tests and treatment for traveler named above. **In the event that I cannot be reached in an emergency,** I hereby give permission to the physician selected by Ventures Travel, LLC to secure and administer treatment including hospitalization, injections, anesthesia or surgery, for the traveler named above. I give permission to obtain copies of treatment and health records from any provider and I agree to release information and records necessary for treatment. Ventures Travel, LLC cannot assume responsibility for any medical expenses that may occur if medical care must be sought.

\_\_\_\_\_  
**(required)** Signature of parent, legal guardian, applicant if own guardian or authorized person Date signed

**Publicity Release:** I hereby\_ give permission for Ventures Travel, LLC to use any pictures, photographs, film or recordings taken of the traveler named above for publication in brochures, electronic mail/website, magazines, news articles, newsletters, newspapers, and other publications in order to convey information about Ventures Travel, LLC to the general public, potential customers, and for recruiting volunteers or staff as trip leaders/guides.

\_\_\_\_\_  
**(optional)** Signature of parent, legal guardian, applicant if own guardian or authorized person Date signed

\_\_\_\_\_  
**Check off if unable to obtain signatures at this time. A copy of this section has been provided to the appropriate individual for signatures. It will be mailed (once signed) to the office of Ventures Travel, LLC at least ONE MONTH PRIOR to departure date.**

**PAYMENT AGREEMENT: Please read carefully. Check and complete the appropriate blanks.**

I/we agree to pay for the services provided by Ventures Travel, LLC. I/we understand that the cost of service includes: staff supervision, cost of accommodations, attractions, method of travel, and most of the meals. I/we understand that the spending money I bring will cover the cost for a small number of meals while on vacation (determined by length of trip) and all souvenirs.

I/we will pay the actual cost of trip\_\_\_\_\_ I/we will pay discount fee\_\_\_\_\_ Full payment is enclosed\_\_\_\_\_ Deposit only enclosed\_\_\_\_\_

I cannot pay for my trip all at once. Here is my plan for payments:

\_\_\_\_\_ Bill me once for balance (due within 30 days of completing the trip), or: \_\_\_\_\_ I will make monthly payments in the amount of \$\_\_\_\_\_.

\_\_\_\_\_ I will pay by credit card. Bill \$ \_\_\_\_\_ to my: \_\_\_\_\_ Master Card \_\_\_\_\_ Visa \_\_\_\_\_ American Express \_\_\_\_\_ Discover Card # \_\_\_\_\_ Printed name on Card: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Signature: \_\_\_\_\_

\_\_\_\_\_ I will have help in paying for my vacation. Payments will come from these sources:

\$ _____	_____	_____	_____	_____	_____
Amount	Name of person or organization	Address	City	State	Zip
\$ _____	_____	_____	_____	_____	_____
Amount	Name of person or organization	Address	City	State	Zip
\$ _____	_____	_____	_____	_____	_____
Amount	Name of person or organization	Address	City	State	Zip

I would like to contribute to the "Scholarship Fund" to help another person take a Ventures Travel, LLC vacation. Amount donated: \$ \_\_\_\_\_

Is applicant eligible to receive Waiver Service Funds? \_\_\_ Yes \_\_\_ No

If yes, please check the waiver that applies:  Consumer Directed MR/RC  CADI  MR/RC  Other \_\_\_\_\_

For office use only: Traveler Name: _____ Record # _____
Actual cost of trip: \$ _____
Discount fee: \$ _____
Total amount of scholarship approved: \$ _____

Traveler's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Name of Person Completing Application \_\_\_\_\_

**DISABILITY/OTHER CONDITIONS: Check one:** \_\_\_\_\_ **with disability/other condition** \_\_\_\_\_ **without disability/other condition**  
*Please check all boxes that apply. Conditions in bold print \* require an additional questionnaire which our office will send you.*

\_\_\_\_\_ Ability Level is: \_\_\_\_\_ Mild \_\_\_\_\_ Moderate  
\_\_\_\_\_ Asperger Syndrome  
\_\_\_\_\_ Autism, type: \_\_\_\_\_  
\_\_\_\_\_ Attention Deficit Disorder or \_\_\_\_\_ Attention Deficit Hyperactivity Disorder  
\_\_\_\_\_ Alzheimer's or other Dementia (Beginning stages)  
\_\_\_\_\_ Blind/Vision impaired, explain \_\_\_\_\_  
\_\_\_\_\_ Wears glasses \_\_\_\_\_ Uses cane  
\_\_\_\_\_ Cerebral Palsy  
\_\_\_\_\_ Deaf/hearing impaired, explain \_\_\_\_\_  
\_\_\_\_\_ Wears hearing aid(s); \_\_\_\_\_ Uses sign language (needs interpreter)  
\_\_\_\_\_ Down Syndrome  
\_\_\_\_\_ Mental Retardation  
\_\_\_\_\_ Oppositional Defiant Disorder  
\_\_\_\_\_ Pervasive Developmental Disorder  
\_\_\_\_\_ Prader-Willi Syndrome  
\_\_\_\_\_ Rett Syndrome  
\_\_\_\_\_ Tourette Syndrome  
\_\_\_\_\_ Williams Syndrome  
\_\_\_\_\_ Further explanation for any condition or other disorder,  
Explain: \_\_\_\_\_  
\_\_\_\_\_

Other medical issues/items/notes:  
\_\_\_\_\_ Allergies to \_\_\_\_\_  
\_\_\_\_\_ Reaction: \_\_\_\_\_ Hives \_\_\_\_\_ Difficult breathing  
\_\_\_\_\_ Anaphylaxis \_\_\_\_\_ Other \_\_\_\_\_  
\_\_\_\_\_ Arthritis  
\_\_\_\_\_ \***Catheter:** \_\_\_\_\_ intermittent \_\_\_\_\_ in-dwelling  
\_\_\_\_\_ colostomy or ileo appliances  
\_\_\_\_\_ \***Diabetes**, type \_\_\_\_\_  
\_\_\_\_\_ **insulin dependent**  
(traveler must be able to administer injections)  
\_\_\_\_\_ \***Epilepsy/Seizures**, type & frequency: \_\_\_\_\_  
\_\_\_\_\_ \***Orthopedic appliances**  
\_\_\_\_\_ \***Respiratory**, type \_\_\_\_\_  
List irritants \_\_\_\_\_  
\_\_\_\_\_ Heart problems, explain \_\_\_\_\_  
\_\_\_\_\_

**Special Appliances/Ambulation**

Does traveler use a wheelchair? \_\_\_\_\_ Yes \_\_\_\_\_ No (Ventures Travel does not provide wheelchairs. If needed, traveler must bring own chair.)  
\_\_\_\_\_ wheelchair used for long distances only \_\_\_\_\_ wheelchair used full-time \_\_\_\_\_ Manual \_\_\_\_\_ Electric \_\_\_\_\_ Stroller  
\_\_\_\_\_ traveler transfers self \_\_\_\_\_ traveler needs assistance to transfer \_\_\_\_\_ traveler can bear weight \_\_\_\_\_ traveler needs total assistance  
Additional care instructions: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ traveler has range of motion exercises, how often? \_\_\_\_\_ Please attach a copy of exercises.  
\_\_\_\_\_ traveler requires assistance in walking. Assistance is: \_\_\_\_\_ support from another person \_\_\_\_\_ cane \_\_\_\_\_ walker \_\_\_\_\_ crutches  
Describe traveler's gait: \_\_\_\_\_ stable \_\_\_\_\_ unsteady \_\_\_\_\_ walks slowly \_\_\_\_\_ falls easily  
Traveler wears: \_\_\_\_\_ **orthotics**, circle left or right \_\_\_\_\_ prosthesis, circle left or right \_\_\_\_\_ braces daytime \_\_\_\_\_ braces nighttime

**Sleeping**

\_\_\_\_\_ traveler sleeps through the night \_\_\_\_\_ \*traveler does not sleep through the night \_\_\_\_\_ \*traveler has difficulty sleeping  
\*Explain: \_\_\_\_\_  
Does traveler have any bedtime rituals that are important for us to know about? \_\_\_\_\_ Yes \_\_\_\_\_ No Please describe: \_\_\_\_\_  
\_\_\_\_\_

**Eating**

Traveler is \_\_\_\_\_ right-handed \_\_\_\_\_ left-handed Normal appetite is: \_\_\_\_\_ large \_\_\_\_\_ medium \_\_\_\_\_ small  
Assistance level for eating: \_\_\_\_\_ No help \_\_\_\_\_ some help \_\_\_\_\_ all help, explain: \_\_\_\_\_  
Traveler has food allergy to: \_\_\_\_\_  
Reaction? \_\_\_\_\_ hives \_\_\_\_\_ difficulty breathing \_\_\_\_\_ nausea \_\_\_\_\_ other, explain \_\_\_\_\_  
Is traveler on a special diet/restriction? \_\_\_\_\_ Yes \_\_\_\_\_ No, describe: \_\_\_\_\_  
\_\_\_\_\_ Does traveler have trouble: \_\_\_\_\_ swallowing \_\_\_\_\_ chewing \_\_\_\_\_ drinking liquids  
Traveler uses: \_\_\_\_\_ special utensils (bring) \_\_\_\_\_ chopped food \_\_\_\_\_ dietary supplement (bring) \_\_\_\_\_ straw \_\_\_\_\_ **feeding tube**  
Further instructions/information about eating or diet: \_\_\_\_\_  
\_\_\_\_\_

**Personal Care**

Traveler's current weight \_\_\_\_\_ current height \_\_\_\_\_ Traveler prefers: \_\_\_\_\_ baths \_\_\_\_\_ showers  
Assistance level: \_\_\_\_\_ No help \_\_\_\_\_ \*some help \_\_\_\_\_ \*all help \***indicate areas where help is needed, check all that apply:**  
\_\_\_\_\_ washing face and hands \_\_\_\_\_ mixing water for bath or shower \_\_\_\_\_ brushing teeth \_\_\_\_\_ washing hair \_\_\_\_\_ rinsing hair \_\_\_\_\_ shaving  
\_\_\_\_\_ combing hair \_\_\_\_\_ menstrual care \_\_\_\_\_ washing body areas, explain: \_\_\_\_\_  
\_\_\_\_\_ Traveler wears dentures \_\_\_\_\_ cares for dentures independently \_\_\_\_\_ takes dentures out at night \_\_\_\_\_ needs assistance in denture care  
Further personal care instructions: \_\_\_\_\_  
\_\_\_\_\_

Traveler's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Name of Person Completing Application \_\_\_\_\_

**Bathroom Use**

Traveler is: \_\_\_\_\_ independent in bathroom \_\_\_\_\_ needs reminders to use bathroom \_\_\_\_\_ \*needs help in the bathroom \_\_\_\_\_ \*is incontinent, \*explain: \_\_\_\_\_  
Is traveler on a bathroom schedule? \_\_\_\_\_ Yes \_\_\_\_\_ No Please explain: \_\_\_\_\_  
Does traveler use: (please bring all supplies) \_\_\_\_\_ \*urinal \_\_\_\_\_ \*adult depends or attends \_\_\_\_\_ \*catheter or \_\_\_\_\_ **intermittent catheter** \_\_\_\_\_ \*colostomy or ileo appliances Explain any \* items: \_\_\_\_\_

**Communication**

Does Traveler understand and respond to questions? \_\_\_\_\_ Yes \_\_\_\_\_ No Traveler is able to read: \_\_\_\_\_ Yes \_\_\_\_\_ No  
Traveler communicates wants/needs: \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Verbal \_\_\_\_\_ Non-verbal  
If non-verbal, traveler communicates: \_\_\_\_\_ using sign language \_\_\_\_\_ using a communication board or book (please provide)  
Traveler is able to write: \_\_\_\_\_ Yes \_\_\_\_\_ No Any further explanation about communication: \_\_\_\_\_

**Dressing**

Traveler is: \_\_\_\_\_ independent in choosing/putting on clothes \_\_\_\_\_ needs assistance with choosing/putting on clothes \_\_\_\_\_ \*needs total help  
Traveler needs assistance with: \_\_\_\_\_ buttons \_\_\_\_\_ shoes \_\_\_\_\_ shoe laces \_\_\_\_\_ socks \_\_\_\_\_ fasteners \_\_\_\_\_ zippers \_\_\_\_\_ shirt \_\_\_\_\_ bra \_\_\_\_\_ pants \_\_\_\_\_ reminders to wear clean clothes \_\_\_\_\_ separating clean and dirty clothes Any further explanation: \_\_\_\_\_

**Social Interaction Skills: Check all that apply**

\_\_\_\_\_ No unusual behavior \_\_\_\_\_ attaches to male staff \_\_\_\_\_ attaches to female staff \_\_\_\_\_ withdrawn or shy \_\_\_\_\_ \*verbal aggression  
\_\_\_\_\_ \*self-injurious \_\_\_\_\_ \*physically aggressive toward others \_\_\_\_\_ \*physically aggressive toward objects has temper tantrums  
\_\_\_\_\_ wanders unintentionally (distracted) \_\_\_\_\_ wanders or runs away intentionally \_\_\_\_\_ other \_\_\_\_\_  
\_\_\_\_\_ \*traveler is on a **behavior modification or management plan** (explain below and send copies if expected to comply on vacation)  
\_\_\_\_\_ traveler has been away from home before \_\_\_\_\_ \*traveler experiences homesickness \_\_\_\_\_ \*traveler has fears that will impact vacation  
Explain any checked behaviors (and those with \*), their frequency and suggested method of dealing with behavior: \_\_\_\_\_

**Personal Information**

In order to maximize staff supervision, accommodations are based on sleeping arrangements which require sharing double/queen/king size beds.  
Traveler is comfortable sharing a bed? \_\_\_\_\_ Yes or \_\_\_\_\_ No Traveler will pay **extra** for a single bed? \_\_\_\_\_ Yes (\$25/night) or \_\_\_\_\_ No  
Is there a traveler on this vacation they would feel comfortable sharing a bed with? Name of traveler: \_\_\_\_\_

Travelers may go to a social function/restaurant where alcohol is served. May he/she have alcohol? \_\_\_\_\_ Yes or \_\_\_\_\_ No. If yes, what type of alcoholic beverage may be chosen? \_\_\_\_\_ Beer \_\_\_\_\_ Wine \_\_\_\_\_ Liquor Suggested drink limit? \_\_\_\_\_

Traveler is: \_\_\_\_\_ independent in managing spending money \_\_\_\_\_ will check spending money in with staff. Explain any other money management concerns: \_\_\_\_\_

Traveler is: \_\_\_\_\_ independent in taking medications \_\_\_\_\_ under staff supervision to ensure meds taken \_\_\_\_\_ staff needs to administer meds

Traveler smokes: \_\_\_\_\_ Yes or \_\_\_\_\_ No If a smoker, traveler manages cigarettes: \_\_\_\_\_ Yes or \_\_\_\_\_ No \*Staff hold cigarettes: \_\_\_\_\_ Yes

\*Traveler on cigarette limit: \_\_\_\_\_ Yes, how many and how often? \_\_\_\_\_

Traveler enjoys swimming \_\_\_\_\_ Yes \_\_\_\_\_ No Traveler rides a \_\_\_\_\_ 2-wheeler w/ helmet \_\_\_\_\_ 3-wheeler w/ helmet \_\_\_\_\_ No bike riding

Traveler has: \_\_\_\_\_ attended a Ventures Travel trip \_\_\_\_\_ traveled w/ a similar company—which company? \_\_\_\_\_

Additional information regarding activities enjoyed, likes, dislikes, fears or activity restrictions which may be helpful to our staff: \_\_\_\_\_

**Each traveler sends a post card to a family member/friend/coworker/housemate. Please identify a person (and their relationship) and provide a complete mailing address:** \_\_\_\_\_