For Office Use Only

WC ___
OA ___
HR ___

Date Received:_____ Staff Initials:____

Please submit a recent photo of the traveler when returning this paperwork.

Trip Location: _____

Trip Date: _____

General Information

Traveler's legal name_____ Birth date_____ Age_____

Street address_____ City_____ State_____ Zip code_____

Phone ( ) _____ Sex: Male_____ Female_____

Airport of choice (If not Minneapolis/St Paul, other fees may apply) _____

Passport Information (if applicable)

Name on passport:_____ Passport number:_____

Date issued:_____ Expiration date:_____ Country of issuance:_____

Contact Information

Legal Guardian/Conservator Information

Name_____ Phone_____

Street address _____ City_____ State_____ Zip_____

Relationship to traveler_____

Residential Contact Information (if applicable)

Name_____ Phone_____

Street address _____ City_____ State_____ Zip_____

Relationship to traveler_____

Communication Information

Please check one box for each question below. Hard copies will only be sent to one person, additional copies can be sent via email upon request.

Send billing information to:	☐ Traveler	☐ Guardian/Conservator	☐ Residential contact
Send consents and waiver to:	☐ Traveler	☐ Guardian/Conservator	☐ Residential contact
Send pre/post trip materials to:	☐ Traveler	☐ Guardian/Conservator	☐ Residential contact

(Pre/Post trip materials include: Itinerary, Cash ledger, Packing Guide, Medication Envelopes/Instructions, Luggage Tag and Trip Picture Disc)

Staff to Traveler Ratio Please explain if other than 1:4 (additional fees may apply)

☐ 1:4 (or less) ☐ 1:1

Behavioral Concerns (Check all that apply):

If traveler has any behavioral concerns please complete the "Behavioral Supports" form.

_____ Hitting	_____ Refusal to leave an area	_____ Self injurious
_____ Biting	_____ Crying for no apparent reason	_____ Yelling
_____ Eloping	_____ Throwing objects	_____ Swearing
_____ Vehicle safety	_____ Refusal to take medications	_____ Inappropriate sexual behavior

Other (specify below): _____ **Traveler has no behavioral concerns**

Medical History (Check all that apply; please describe severity and any needed assistance in the section below)

_____ **Heart problems (please explain below)**
_____ **High blood pressure**
_____ **Pacemaker**
_____ **Seizure disorder**
Controlled: yes___ no___
PRN Medication: yes___ no___
_____ **Diabetes**
Controlled: yes___ no___
Injections: yes___ no___
With staff assistance: yes___ no___
Blood testing: yes___ no___
With staff assistance: yes___ no___

_____ **Asthma**
_____ **Pulmonary disease**
_____ **Communicable disease**
_____ **Blind**
_____ **Deaf**
_____ **Edema**
_____ **Migraines**
_____ **Traumatic brain injury**
_____ **Stomach problems or ulcers**
_____ **Uses portable oxygen (please describe device below)**
_____ **Catheter (please explain below)**
_____ **Ostomy (please explain below)**

Description/assistance needed of above or Other not listed (specify):

Lifestyle Choices:

_____ **Uses tobacco products**

_____ **Consumes alcohol**

*It is Hammer Travel's policy that no more than two alcoholic beverages are consumed daily.

Allergies

Does traveler have any allergies? Yes No **If "Yes", please describe below:**

Medicines:_____

Food:_____

Other:_____

Describe allergic reaction: _____

_____

Diet

Is traveler on a special diet? Yes No

If "Yes", please describe:

Toileting

Does traveler need assistance toileting? Yes No

If "Yes", please describe:

Daily routines

Usual bed time:_____ **Preferred activity length:**_____

Naps throughout day: Yes No **Enjoys shopping:** Yes No

Slow to get started in the AM: Yes No **Is alright in larger group settings:** Yes No

Difficulty going to bed: Yes No **Is alright in loud settings:** Yes No

Additional Information (Check all that apply) If you check "Needs assistance" please describe below

Eating

_____ No assistance needed
_____ Needs assistance*
_____ Slow eater
_____ Needs food cut into pieces
_____ Needs food pureed

Vision

_____ No difficulty seeing
_____ Wears glasses
_____ Wears contact lenses
_____ Traveler is blind

Dressing

_____ No assistance needed
_____ Needs assistance*

Swimming

_____ Independent
_____ Needs life jacket/floats
_____ Needs to stay waist deep
_____ Can't swim

Speaking

_____ No difficulty speaking
_____ Speaks slowly
_____ Uses computer/machine to speak
_____ Is non-verbal

Bathing

_____ No assistance needed
_____ Needs assistance*
_____ Needs roll in shower
_____ Needs shower bench/chair

Hearing

_____ No difficulty hearing
_____ Need to speak slowly
_____ Needs statements repeated
_____ Wears hearing aid/s
_____ Traveler is deaf

Ambulation

_____ No help needed
_____ Needs help on unstable ground
_____ Arm in arm assistance when walking
_____ Uses a walker
_____ Wheelchair for long distances only
_____ Uses a manual wheelchair
_____ Uses an electric wheelchair
Wheelchair weight: _____
Battery type: _____

If wheelchair is used:

_____ Requires a wheelchair accessible van
_____ Can self transfer
_____ Needs assistance to transfer
_____ Can bear weight
_____ Traveler is a 2 person transfer
Traveler's weight _____
_____ Uses a lift at home

Please describe below, any assistance needed with personal cares, transfers, etc.

Please note: "transfer chairs" cannot be used on trips. If using a manual wheelchair, travelers may only bring wheelchairs with big back wheels.

***Additional Information (assistance needed, routines, likes/dislikes, etc.):**