



Do you require travel insurance?

Yes No

Do you require a pick-up, if offered, for your vacation? (extra charges applies)

Yes No

Do you require \$150 pre trip accommodations?

Yes No

Please refer to Vacation brochure or website for dates and fees.

1st choice:	Dates:	Code:	Fee:	
2nd choice:	Dates:	Code:	Fee:	
3rd choice:	Dates:	Code:	Fee:	Subtotal A: \$

➔ ONTARIO CAMP VACATIONS:

Please refer to Vacation brochure or website for dates and fees.

1st choice:	Dates:	Code:	Fee:	
2nd choice:	Dates:	Code:	Fee:	
3rd choice:	Dates:	Code:	Fee:	

Would like to attend more than 1 choice Yes No

If yes, which choices 1st 2nd 3rd **Subtotal B: \$**

Round-trip Transportation (Paisley Only): Toronto \$190 Hamilton \$175 Guelph \$165

Please call for details regarding one-way fees and custom services.

Meeting point and departure and arrival detail will be set with confirmation. Guests who use a wheelchair must be able to transfer onto the bus, and chair must fold for storage. Transportation service availability is subject to demand.

Subtotal C: \$

Day Trips (Paisley Only):

Week 1	Week 2	Day Trip	3:1	1:1	Fee:
<input type="radio"/>	<input type="radio"/>	PORT ELGIN BEACH (July/August only)	<input type="radio"/> \$20	<input type="radio"/> \$25	Fee:
<input type="radio"/>	<input type="radio"/>	MINI-GOLF (July/August only)	<input type="radio"/> \$25	<input type="radio"/> \$35	Fee:
<input type="radio"/>	<input type="radio"/>	BOWLING	<input type="radio"/> \$25	<input type="radio"/> \$35	Fee:
<input type="radio"/>	<input type="radio"/>	DINNER OUT	<input type="radio"/> \$40	<input type="radio"/> \$50	Fee:
<input type="radio"/>	<input type="radio"/>	MUSEUM	<input type="radio"/> \$25	<input type="radio"/> \$30	Fee:
<input type="radio"/>	<input type="radio"/>	HORSEBACK RIDING (July only)	<input type="radio"/> \$35	<input type="radio"/> \$45	Fee:

Subtotal D: \$

For more information visit our website or refer to the brochure.

Subtotal E: \$

Add Subtotals for Total Cost: _____

Less Deposit (Excursions and Camps \$200 per week): _____

TOTAL BALANCE DUE (Paid 60 days prior to departure): _____

Payment Plan?

Ask us how scheduled payments can help you budget ahead.

Payment Method

Cheque for Deposit Enclosed (please make payable to Christian Horizons)

Visa 

MasterCard 

American Express 

Card #: _____

Expiry Date: _____

Cardholder's Name: _____

Cardholder's Signature: _____

Phone Number: () _____

➔ AUTHORIZATION:

Permission:

I permit pictures and video taken on vacation to be used by Christian Horizons for general and educational promotion: Yes No

I permit the guest to make collect phone calls to this number: ()

Guest/Traveller Waiver

Any vacation carries along with it the risk of injury to me as a person or damage to my property. I, the undersigned, understand I am a prospective participant of a Supported Vacation at my own risk and I release Christian Horizons and its agents from all liability for any injury to me or damage to my property that may result from any cause whatsoever.

I am advised that I can call Christian Horizons to find out about the possible risks or damages on the proposed tour that I have requested before I sign this agreement and until departure.

I understand that if I need to return home from a vacation due to behavioural or pre-existing medical reasons, that I am responsible for the return travel cost and any associated expenses. I understand that refunds are pro-rated and do not include original deposit or non-refundable prepaid expenses.

I confirm that all information provided is accurate and complete to the best of my knowledge. I understand that the Supported Vacations program cannot provide supports for challenging or aggressive behaviour. The guest has been consulted and informed about the vacation and they have chosen to spend their vacation time in this way.

I hereby give my consent for the staff involved to secure MEDICAL EMERGENCY care for _____ in the event that it is needed while he/she is on vacation with Christian Horizons. Neither Christian Horizons, nor its employees, will be liable for any financial costs arising from the emergency care.

Date: _____

Signature of Applicant: _____

Printed Name of Applicant: _____

Date: _____

Signature of Support Provider: _____

Printed Name of Support Provider: _____

Use a separate page for further information that may be helpful in providing proper care, assistance and support to guest.

Cheques should be made payable to Christian Horizons. Deposits are non-refundable unless the registration is not accepted or there are no openings available, in which case the full deposit will be returned.

Cancellation

If you are forced to cancel your vacation due to illness or emergency, you must notify Christian Horizons (Failing to send the balance of your fees does not constitute cancellation). Written cancellation at least 60 days prior to vacation commencement, or cancellation due to illness, with a supporting medical certificate, will receive a full refund, minus deposit and non-refundable prepaid expenses. This does not include partnership excursions with Great Canadian Tours.

Registration for Camps and Excursions:

CHRISTIAN HORIZONS CONFERENCE CENTRE
4442 Bruce Road #1, RR #2
Paisley, Ontario N0G 2N0
Phone: 519-353-5756 • Fax: 519-353-5136
www.christian-horizons.org



OFFICE USE ONLY

Approved: _____
 Date: _____
 Ratio: _____
 Blocks: _____



We will honour God and value people in all we do and with all our resources.

2010 VACATION REGISTRATION FORM

➔ PERSONAL DETAILS:

Name: (as it appears on birth certificate)	First: _____	Middle: _____	Last: _____
Address:	Street: _____	Apt#: _____	
	City: _____	Province/State: _____	Postal Code/Zip: _____
	Phone: () _____	E-mail: _____	Fax: () _____
Date of birth:	MM/DD/YY / /	Gender: M / F	Preferred name: _____
			Guest #: _____ (if assigned)

➔ PLACE OF WORSHIP (this information is collected for staff recruiting purposes):

Name of church:	_____		
Address:	Street: _____		
	City: _____	Province/State: _____	Postal Code/Zip: _____
Contact name:	_____		Phone: () _____

➔ PRIMARY CONTACT:

Name of organization/ association:	_____		Program Name: _____	Relationship to guest: _____
Contact name:	First: _____	Last: _____		
Address:	Street: _____		Apt#: _____	
	City: _____	Province/State: _____	Postal Code/Zip: _____	
	Phone: () _____	Cell: () _____	E-mail: _____	

Are you at home while guest is with us? Yes No Not sure

If no, please include your phone number while away and dates you plan to be away:

➔ SECONDARY EMERGENCY CONTACT:

Contact name:	First: _____	Last: _____		
Relationship to guest:	_____			
Address:	Street: _____		Apt#: _____	
	City: _____	Province/State: _____	Postal Code/Zip: _____	
	Phone: () _____	Cell: () _____	E-mail: _____	

Are you at home while guest is with us? Yes No Not sure

If no, please include your phone number while away and dates you plan to be away:

➔ **DIAGNOSIS AND COMMUNICATION:**

Diagnosis: (check all that apply)

- None Autism Blindness Brain or neurological damage, chronic brain syndrome
 Chemical dependency Deafness Developmental disability Epilepsy or seizures
 Cerebral palsy Mental illness (formal diagnosis), psychosis, schizophrenia, etc.
 Situational mental health problem (formal diagnosis), depression, anxiety, fearfulness, mood disturbance
 Syndrome (please specify): _____ Other (please specify): _____

Based on the above, what is the primary diagnosis of the applicant? (list one)

Does the guest have any physical limitations? Describe.

Does the guest use a wheelchair?

- Yes No Electric

Does the guest require assistance for transfers?

- 1 Person 2 People Mechanical Lift Independent

Is the guest able to use a top bunk?

- Yes No

Is the guest's speech understandable?

- Yes No Somewhat

If communication is an issue, please attach a picture to this application for positive identification for medication.

Does the guest use:

- Sign Language Bliss Pic symbols Other

➔ **SOCIAL/BEHAVIOURAL CONSIDERATIONS:**

Is there someone the guest wants to share a room with?

Name:

First:

Last:

Has the guest been away from home before?

- Yes – length of time No

How long can the guest be left alone safely?

Length of time

Does the guest enjoy swimming?

- Yes No Shallow Deep

Life jacket required?

- Yes No

What recreational activities does the guest presently enjoy?

How do they participate?

- Willingly With encouragement Seldom Never

Does the guest have any significant fears?

- Yes No

If yes, please describe how we can help.

How does the guest:

Respect the privacy of others? Good Fair Poor

Initiate interaction with others? Good Fair Poor

Interact in a group? Good Fair Not at all

Tolerate frustration? Tolerates Withdraws Cannot tolerate, loses control

Problem solve? Independent Some assistance Full support needed

Adapt to change? Adapts Withdraws Cannot adapt, loses control

Describe the guest's:

Knowledge of basic manners Good Fair Poor

Consideration of others Good Fair Poor

Describe the guest's orientation:

- Aware of person, place, time, situation Generally aware but inconsistent in 1 or 2 areas Unaware of person, place, time, situation

Does the guest engage in behaviours that require you to intervene?

- Never Frequently Rarely

Describe the behaviour: (severity, frequency, cause and early warning signs)

How do you typically intervene in these instances?

Have there been any behavioural changes in the last year?

Please describe, if any: Yes No

Is the guest on medication that controls or alters behaviour?

- Yes No

Does the guest use medication on an as needed (PRN) basis to manage behaviours?

- Yes No

(Please include details on MAR sheet and ensure medication accompanies guest)

What change to behaviour does medication facilitate?

Does the guest use a behaviour modification program?

- Yes No

(Please outline in detail on a separate page.)

➔ SEXUALITY:

Describe how we can best support this individual while vacationing with other guests, sometimes in a family setting. Inform us of protocols related to sexual behaviour.

➔ MEDICAL INFORMATION:

A doctor's medical examination is not required, but the completion of this questionnaire is requested to confirm the general condition of the guest's health.

Is guest subject to seizures? Yes No Frequency and type:

(If guest is on medication to control seizures, please ensure full details are included on MAR sheet and medication accompanies guest.)

Describe a typical seizure: (movement, length, plan of action after seizure, expected behaviour before and after, etc.)

When should 911 be called?

Do you require a record of seizures? Yes No

If yes, how detailed?

If guest has Down Syndrome, have they been tested for Atlanto-Axial Dislocation? Yes No N/A

Result:

Allergies: (note severity; i.e. foods, medicines, plants)

Intervention for allergic reaction: (e.g. Benadryl, epi-pen, hospitalization, etc.)

Is the guest a Hepatitis B Carrier? Yes No

What is the guest's weight?

Please comment on any other conditions/communicable diseases which present a health hazard.

➔ PHYSICAL HEALTH:

Does the guest experience:

- | | | | |
|---|----------------------------------|--|---|
| <input type="radio"/> Shortness of breath | <input type="radio"/> Headaches | <input type="radio"/> Joint inflammation | <input type="radio"/> Insomnia |
| <input type="radio"/> Edema (tissue swelling) | <input type="radio"/> Nightmares | <input type="radio"/> Sleep apnea | <input type="radio"/> Over-fatigue |
| <input type="radio"/> Persistent cough | <input type="radio"/> Diarrhoea | <input type="radio"/> Constipation | <input type="radio"/> Anuria (kidney dysfunction) |

How are these problems normally treated?

Do any of these problems need to be monitored by our health care staff?

Please indicate if any abnormalities exist and comment in detail on:

- | | | | |
|----------------------------|-----------------------------|------------------------------------|-----------------------------------|
| <input type="radio"/> Eyes | <input type="radio"/> Nose | <input type="radio"/> Ears | <input type="radio"/> Mouth |
| <input type="radio"/> Skin | <input type="radio"/> Spine | <input type="radio"/> Neurological | <input type="radio"/> Chest/Heart |

Comments:

Does guest exaggerate physical or other problems to seek attention? Yes No

If yes, please explain.

Menstruation: Normal Pain/Discomfort

(If cycle is due to begin while on vacation, please provide supplies and inform support staff.)

➔ OTHER HEALTH CONCERNS:

Recent major illness: When: Did guest visit the doctor? Yes No

Has the guest been hospitalized in the last year? Yes No

Please indicate reason(s) for hospitalization:

Have there been any significant medical or physical changes in the last year? Yes No

Please describe:

Are all vaccinations and inoculations up to date? Yes No

If no, please ensure that they are before vacation begins.

Does the guest have conditions requiring medical treatment while on vacation? Yes No

Please explain:

➔ DIET:

Assistance needed at meal times:

- Fully independent Needs food cut Needs food pureed Uses drinking straw
 Uses adapted utensils (please send with guest) GI feeding Needs to be fed by staff

Does the guest have any eating or food-related disorders? Yes No

Please indicate the disorder: Diabetes Anorexia Bulimia Prader-Willi

Other:

Severity:

Does the guest have any food allergies or dietary restrictions that need to be monitored by staff? Yes No

Please list food allergies and what will occur if food is consumed, food restrictions or special diet requirements.

If guest is on a weight-loss program or has diabetes, please indicate what sort of snacks, desserts, etc. are allowed.

If a special diet must be strictly adhered to, please provide a meal plan on a separate page.

➔ Please indicate, by entering the appropriate letter, the level of care required for each activity

I – Independent R – Reminders Only V – Verbal Prompting H – Hand Over Hand Assistance F – Full Assistance

- | | | | | |
|-----------------------------------|---|---------------------------------------|--|--|
| <input type="checkbox"/> Dressing | <input type="checkbox"/> Showering | <input type="checkbox"/> Washing hair | <input type="checkbox"/> Brushing hair | <input type="checkbox"/> Deodorant |
| <input type="checkbox"/> Shaving | <input type="checkbox"/> Brushing teeth | <input type="checkbox"/> Using toilet | <input type="checkbox"/> Menstrual hygiene | <input type="checkbox"/> Incontinence supplies |

(If needed, sufficient incontinence supplies to last entire vacation must be sent with guest.)

Level of support recommended (please take into account the active nature of being on vacation.)

- Independent 3 guests: 1 support staff 1 guest: 1 support staff (additional cost)

Please explain: