

Couples Retreat 2018 Application

Registration is available on a first-come-first-serve-basis, based on availability of appropriate accommodations and space.

Name of person with aphasia (Camper): _____

Male Female Date of birth: ____/____/____ Month & Year of aphasia diagnosis: ____/____/____

Is your diagnosis Primary Progressive Aphasia (PPA)? Yes No

Address: _____

Telephone Number: _____ Email address: _____

Care Partner who will be accompanying you: _____

Male Female Date of birth: ____/____/____ How long have you been partners: _____

Address (if different): _____

Telephone Number: _____ Email address: _____

Emergency Contact Person & Relationship Telephone Number

Did you meet before or after the stroke or brain injury? _____

What are the biggest challenges you face as a couple living with aphasia? What do you hope to gain from attending the retreat? _____

- Couples Retreat (May 4th – 6th)** \$310 per couple = \$_____
- We would like to REQUEST a partial scholarship to attend in the amount of \$_____
- We would like to DONATE to the scholarship fund. Amount enclosed: \$_____ (Thank you!)

Please include full retreat registration payment with this form unless you are requesting a partial scholarship.

Payment is non-refundable after April 18th 2018. Registration is not tax deductible.

Make checks payable to and mail this form to:

The Aphasia Network, PO Box 13406, Portland OR 97213

You may also pay online at www.AphasiaNetwork.org - click the Donate button; enter 'Registration' in the Additional Information section; enter 'Couples Retreat' in the Details box; enter your last name in the Details 2 box.

Online registration is also available at www.AphasiaNetwork.org

If you have additional questions, contact us at: (503) 577-1282 or Email: info@aphasianetwork.org

Independence and Assistance for campers:

Campers must be **independent or need only a minimum of assistance with:**

- Dressing & Grooming
- Transferring into & out of the lower bunk beds
- Mobility
- Toileting – *we cannot accommodate incontinence without the use of camper-provided protective garments and the need for a minimum of assistance*
- Eating

Campers are responsible for getting to and from camp. There is no bus service to camp.

Medical Support:

- Nurse on duty 24 hours a day. First aid is available. Vital signs can be monitored on a regular basis.
- Campers are responsible for taking personal prescription medications. **We do not administer medications.**
- Camp is approximately 13 miles from Tillamook Regional Medical Center.
- Most diet preferences/requirements can be accommodated.

Please read **the accompanying Professional Standards and Safety Policies** and **sign your consent:**

I have read and understood the Professional Standards and Safety Policies of The Aphasia Network and hereby agree to abide by the policies outlined in said documents. I am aware that my refusal to follow the policies may result in my discharge from Camp and preclude my participation from Aphasia Network events in the future. Note: Camp Magruder is a drug-free, weapons-free facility

Survivor: _____ Date: _____

Care Partner: _____ Date: _____

PHOTO & VIDEO RELEASE: I give my permission for Aphasia Camp Northwest and/or Pacific University staff, faculty or representatives to photograph, video and/or audio record me directly or incidentally throughout my time at Aphasia Camp Northwest Adventure Weekend. It is my understanding that photographs, video and/or audio recordings may be used for educational, research, and/or promotional purposes. These purposes may include but are not limited to presentations, publications, classroom instruction, marketing outreach (print and/or web media) and other educational, research and/or promotional purposes as determined by the parties listed ABOVE. I understand that if I do not want to be photographed, video and/or audiotaped and am inadvertently recorded, my image and/or audio recording will be removed from any media.

Camper: I agree (yes) I decline (no) Signature: _____ Date: _____

Care Partner: I agree (yes) I decline (no) Signature: _____ Date: _____

Do you use an **assistive device** for **mobility**, please mark all that apply below:

Cane  Indoor Outdoors Chair to Chair to and from toilet



Walker  Indoor Outdoors Chair to Chair to and from toilet

Wheelchair  Indoor Outdoors Chair to Chair to and from toilet

Scooter  Indoor Outdoors Chair to Chair to and from toilet

Person  Indoor Outdoor Chair to Chair to and from toilet

Other: _____ Indoor Outdoors Chair to Chair to and from toilet

(Ex. Gait belts  or Slide boards )

Please indicate how **comfortable** you are **moving around**:







Walking indoors: Not good Kind of good Pretty good Very Good





Walking outdoors: Not good Kind of good Pretty good Very Good

Using stairs: Not good Kind of good Pretty good Very Good




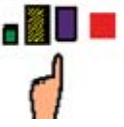










When going to the **toilet**, do you use a:

 <p>raised toilet seat</p>	 <p>commode</p>	 <p>grab bars <input type="checkbox"/> left <input type="checkbox"/> right</p>	 <p>catheter</p>
---	--	--	---

COMMUNICATION

I have difficulty with	none	some	a lot
 <input type="checkbox"/> understanding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
 <input type="checkbox"/> talking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
 <input type="checkbox"/> reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
 <input type="checkbox"/> writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What **helps you to communicate?** Please **circle**.

 writing	 drawing	 communication book
 choices	 iPad or device	 camera
 family or friend	 extra time	 gesture
 pointing	 pictures	 maps
 speak slowly	<i>boating</i> key words	 quiet

DIETARY INFORMATION:

Do you **cough or choke** when eating or drinking? Yes No

Are you **comfortable eating or drinking** the following? *(Check all that apply)*

Hard/Dry/Crunchy foods
Like Toast or Bacon



Soft foods
Like Breads



Pureed foods
Like Applesauce



Liquids
Hot or Cold?



Are you following a **special diet**? Please check all that apply:

- Anything** *(including meat, chicken, fish)* **Vegetarian** **Vegan**
 Low sodium **Diabetic** **Gluten Free**
 Soft Diet *(for chewing or swallowing issues)* chopped soft pureed
 Thickened liquids pudding thick honey thick nectar thick
 Other (please describe): _____

Do you have any **food allergies**? Yes No Do **you use an EpiPen®**? Yes No

What are you allergic to? _____

Describe reaction? _____

Do you use an **alternate means for communication**? Please check all that apply:

- AAC Device iPad Communication Book

Will you bring it to camp? Yes No

If you **currently receive** any of the following **therapies**, please list your provider:

Speech therapist name: _____ Phone: _____

Occupational therapist name: _____ Phone: _____

Physical therapist name: _____ Phone: _____





Psychologists/counselor name: _____





If you attend a **support group**, please list the name and how often/when you attend: _____




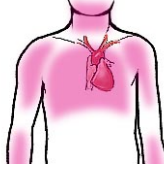


Please tell us about your medical history and state. NAME _____





HEALTH INFORMATION




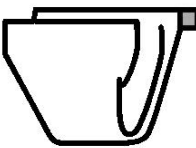

Please circle all that apply.

 <p>stroke</p>	 <p>seizures</p>	 <p>brain injury</p>	 <p>headaches</p>
---	---	--	--

 <p>difficulty swallowing</p> <p><input type="checkbox"/> need thickened liquids</p>	 <p>difficulty with digestion</p>	 <p>diabetes</p> <p><input type="checkbox"/> type 1 <input type="checkbox"/> type 2</p> <p><input type="checkbox"/> low blood sugar</p>	 <p>pregnant</p>
---	--	---	---

 <p>blood pressure</p> <p><input type="checkbox"/> high  <input type="checkbox"/> low </p>	 <p><input type="checkbox"/> angina</p> <p><input type="checkbox"/> heart attack</p>	 <p>heart disease</p>	 <p>difficulty seeing</p> <p><input type="checkbox"/> wear glasses</p>
--	--	--	--

 <p><input type="checkbox"/> chronic pain</p> <p><input type="checkbox"/> arthritis</p>	 <p><input type="checkbox"/> back pain</p> <p><input type="checkbox"/> other joint pain</p>	 <p><input type="checkbox"/> balance issues</p>	 <p>difficulty hearing</p> <p><input type="checkbox"/> wear hearing aid</p>
--	--	---	--

 <p>Edema (swelling)</p>	 <p><input type="checkbox"/> breathing problems</p> <p><input type="checkbox"/> asthma </p>	 <p><input type="checkbox"/> Incontinence</p> <p><input type="checkbox"/> use protective garments</p>	 <p>bowel control problems</p>
---	---	---	---

Please provide any other specific information about medical conditions or concerns: _____

Medications: *(Please attach a separate sheet if there is not enough room below)*

Name	Dosage	When Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any serious illnesses, sprains, broken bones or surgery of any kind in the past 12 months? If yes, please describe:

Other Allergies: Please identify and describe any other allergies (i.e. drugs, insect bites, etc.)

Allergic to	Nature of your Reaction
_____	_____
_____	_____
_____	_____

Do you use an epi pen for these? Yes (please bring it with you) No

IN CASE OF EMERGENCY CONTACT:

Name	Relationship	Day Phone	Night Phone
------	--------------	-----------	-------------

_____	_____	_____	_____
-------	-------	-------	-------

Please note that we are **unable** to provide **support** for some **medical conditions**. We will notify you in advance of Camp if your medical needs cannot be accommodated.

CAMPER (Person with Aphasia)
EMERGENCY MEDICAL AUTHORIZATION

Complete Option 1 OR Option 2. Parent or legal guardian must sign if participant is under 18.

This health history is correct so far as I know, and the person herein described has permission to engage in all camp activities including adventure course, except as noted.

OPTION 1 AUTHORIZATION FOR TREATMENT: I hereby give permission to the medical personnel onsite at Aphasia Couples Retreat to order X-rays, routine tests, treatment, and necessary transportation for the participant named above. In the event that the emergency contacts named above cannot be reached in an emergency, I hereby give permission to the onsite personnel to secure and administer treatment, including hospitalization, for the participant named above. I also agree to be responsible for any expenses which may be incurred in providing emergency medical or surgical treatment to this participant.

Signature: _____ Date: _____

or

OPTION 2 REFUSAL TO CONSENT: I DO NOT give my consent for emergency medical treatment of this participant. In the event of illness or injury requiring emergency treatment, I wish the personnel onsite at Aphasia Couples Retreat to take no action or to: _____

Signature: _____ Date: _____

Care Partners – Please fill out this form with your information

Emergency Medical Authorization & Information

Note that any information you provide will be kept confidential, and shared only with Aphasia Network medical representatives and, if necessary, emergency medical professionals.

Care Partner Name: _____ DOB: _____

Medical conditions:

- ____ Stroke ____ Brain Injury ____ Seizures ____ Headaches
- ____ Heart Disease ____ Angina ____ Heart Attack ____ Blood Pressure High Low
- ____ Pregnant ____ Asthma ____ Breathing problems ____ Difficulty Swallowing
- ____ Diabetes ____ Low blood sugar ____ Digestion Difficulty ____ Balance Issues
- ____ Incontinence ____ Use protective garments ____ Bowl control problems
- ____ Difficulty Hearing ____ Hearing Aid ____ Difficulty Seeing ____ Wear Glasses
- ____ Chronic Pain ____ Arthritis ____ Other joint concerns ____ Back pain ____ Edema

Please provide any other specific information about medical conditions you have:

Medications: *(Please attach a separate sheet if there is not enough room below)*

Name	Dosage	When Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any serious illnesses, sprains, broken bones or surgery of any kind in the past 12 months? If yes, please describe:

Are there any other medical concerns we should know about? If so, please describe:

Please describe any physical limitations you have (walking, climbing stairs, physical exertion). Describe what contributes to the limitation (e.g. debilitating back, knee, wearing leg braces, in a wheel chair, etc.)

Are you following a **special diet**? Please check all that apply:

Anything **Vegetarian** **Vegan** **Low sodium** **Diabetic** **Gluten Free**

Allergies: FOOD ALLERGIES? Yes No If so, please describe: _____

Please identify and describe any other allergies (i.e. drugs, insect bites, dust, etc)

Allergic to

Nature of your Reaction

Do you use an epi pen Yes – Please bring with you No

IN CASE OF EMERGENCY CONTACT:

Name

Relationship

Day Phone

Night Phone

Name

Relationship

Day Phone

Night Phone

Please note that we are **unable** to provide **support** for some **medical conditions**. We will notify you in advance of Camp if your medical needs cannot be accommodated.

CARE PARTNER EMERGENCY MEDICAL AUTHORIZATION

Complete Option 1 or Option 2. Parent or legal guardian must sign if participant is under 18.

This health history is correct so far as I know, and the person herein described has permission to engage in all camp activities including adventure course, except as noted.

OPTION 1 **AUTHORIZATION** FOR TREATMENT: I hereby give permission to the medical personnel onsite at Aphasia Couples Retreat to order X-rays, routine tests, treatment, and necessary transportation for the participant named above. In the event that the emergency contacts named above cannot be reached in an emergency, I hereby give permission to the onsite personnel to secure and administer treatment, including hospitalization, for the participant named above. I also agree to be responsible for any expenses which may be incurred in providing emergency medical or surgical treatment to this participant.

Signature: _____ Date: _____

or

OPTION 2 **REFUSAL** TO CONSENT: I DO NOT give my consent for emergency medical treatment of this participant. In the event of illness or injury requiring emergency treatment, I wish the personnel onsite at Aphasia Couples Retreat to take no action or to: _____

Signature: _____ Date: _____