ADVENTURES
-UNBOUND-

Traveler Information Form

TRAVELER CONTACT INFORMATION

Has the traveler ever traveled independently before? ☐ Yes ☐ No

Traveler Legal Name: _____ ☐ Male ☐ Female

Name must match the name listed on identification

Date of Birth: ____ / ____ / ____

Height: ____ feet _____ inches Weight _____ lbs.

Traveler Address: _____ City_____ State____ Zip _____

Traveler lives: ☐ Independently ☐ with both parents ☐ with one parent

☐ Foster home group (name:_____) ☐ Supported Living center (name:_____)

T-shirt Size: ☐ S ☐ M ☐ L ☐ XL ☐ 2XL ☐ 3XL

Disability / Diagnosis: _____

Primary Contact Person:_____ Relationship to Traveler: _____

Primary Phone: ( ) _____–_____ Email: _____

Address: _____ City_____ State____ Zip _____

How would you prefer to be contacted? Check all that apply: ☐ Mail ☐ Phone ☐ Email

Emergency Contact

Name _____ Phone: ( ) _____–_____

Relationship to Traveler: _____

PAYMENT

- Trips require a 25% deposit at time of registration, with full payment due 30 days prior to date of departure. Registrations made within 30 days of departure will require payment in full.
- Acceptable forms of payments include Check, Money Order or Credit/Debit Cards accepted by Square & Pay Pal. Please make check or money orders out to Adventures Unbound and mail to 824 Woodson Way, Fort Worth, TX 76036.
- Cancellation Policy: All cancellations must be received in writing to Carrie@AdventuresUnboundTravel.com to be accepted. A $25 administration fee will be applied to all cancellations.

DAILY LIVING SKILLS

Eating: ☐ Independent ☐ Some Assistance ☐ Total Assistance

Best way to assist _____

Special Diet? _____

Dressing: ☐ Independent ☐ Some Assistance ☐ Total Assistance

Best way to assist _____

Bathing/hair: ☐ Independent ☐ Some Assistance ☐ Total Assistance

Best way to assist _____

Brushing Teeth: ☐ Independent ☐ Some Assistance ☐ Total Assistance

Best way to assist _____

Toileting: ☐ Independent ☐ Some Assistance ☐ Total Assistance

Best way to assist _____

Transferring: ☐ Independent ☐ Some Assistance ☐ Total Assistance

Best way to assist _____

Mobility: ☐ Walks Alone ☐ Manual Wheelchair ☐ Electric Wheelchair ☐ Other _____

Does traveler use any adaptive equipment/devices? ☐ No ☐ Yes

If yes, what?_____

Communication: Check all that apply: ☐ Speaks Clearly ☐ Uses Gestures ☐ May be to understand

☐ Uses Sign Language ☐ Other_____

Eyesight: ☐ Normal Vision ☐ Some Vision ☐ Blind

Special Instructions: _____

Hearing: ☐ Normal Hearing ☐ Some Hearing ☐ Hearing Aids ☐ Deaf

Special Instructions: _____

Does travel have any special needs during the night? (sleeping, equipment, night light, etc) ☐ Yes ☐ No

If yes, explain: _____

Does traveler have any known fears ☐ Yes ☐ No

If yes, explain: _____

Does the traveler have any behavior concerns? ☐ Yes ☐ No

If yes, explain: _____

_____

What are some management tools used when a behavior occurs? _____

_____

MEDICAL INFORMATION (please be as specific as possible)

Check all that apply: ☐ None ☐ Dehydrates easily ☐ Diabetic ☐ Seizures ☐ Other

Explain Other_____

How do you know when traveler does not feel well? _____

_____

Continued...

Has/Does the traveler had/have any of the following?

- ☐ Recent injury, illness or infectious disease
- ☐ chronic or recurring illness/condition
- ☐ head injury
- ☐ passed out during exercise
- ☐ seizure(s)
- ☐ high blood pressure
- ☐ heart murmur
- ☐ back problems
- ☐ joint problems
- ☐ diabetes
- ☐ asthma
- ☐ history of bed wetting
- ☐ aggressive behavior

Please explain all that apply: _____

_____

_____

Allergies

Medication Allergies & Reaction_____

Food Allergies & Reaction_____

Other _____

Medication

Does traveler take medication on a routine basis? ☐ Yes ☐ No

Please list all medications that the traveler takes routinely. This includes over-the-counter, non-prescription or prescription drugs. Please be sure to include the dosage of the medication (ex. 50mg 2 tablets), the time(s) medication is given and how the traveler takes the medication (with water, crushed in apple sauce, through g-tube, drops, etc.). Be sure to bring enough medication to last the entire duration of the trip. If medications change before the trip departs, please email an updated list as soon as possible.

Medication Name_____

Dosage

Time given: _____AM _____PM _____HS _____other

What is the best way to give the medicine to the traveler?_____

Medication Name_____

Dosage

Time given: _____AM _____PM _____HS _____other

What is the best way to give the medicine to the traveler?_____

Medication Name_____

Dosage

Time given: _____AM _____PM _____HS _____other

What is the best way to give the medicine to the traveler?_____

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INSURANCE INFORMATION

Is client covered under Medicare? ☐ Yes ☐ No If Yes, Medicare # _____

Is the client covered by a family medical insurance? ☐ Yes ☐ No

Health Insurance Carrier: _____

Policy Number: _____

Address of Carrier: _____ City_____ State____ Zip _____

Insurance Policy is under what name?_____

By signing this form, I give permission for photos of the above listed traveler taken on trips and at events to be used in marketing materials for Adventures Unbound, including but not limited, newsletters, social media, website and future printing materials. In consideration of the above listed traveler, I hereby, for the traveler, assume any and all risks which might be associated with the trips and events participated in. I acknowledge that these trips and events may involve inherent risk of injury. I agree that Adventures Unbound, its owner, volunteers and all representatives will not be liable for any injury, including, without limitation, personal, bodily, or mental injury, economic loss or any damage to the above listed traveler resulting from the negligence of the Adventures Unbound or any of the other parties listed above.

By submitting this form, I attest that the information provided on this form is true and accurate to the best of my ability.

_____

Printed name of person filling out form

_____ _____

Signature Date

ADVENTURES
-UNBOUND-

Adventures Unbound Travel
Providing supervised trips
for adults with disabilities

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