AUGUST 10-11, 2019

Doors open at 10:00 am Saturday, the retreat ends at 3 pm Sunday

The Benedict Inn Retreat and Conference Center: 1402 Southern Ave, Beech Grove, IN

A FEW THINGS YOU'LL NEED…

- O ALL retreat forms filled out and turned in no later than July 18, 2019
- O Bed linens (pillow(s), sheets, blanket or sleeping bag) almost all beds are twin
- O Bath towel and wash cloth
- O Toiletries (soap, shampoo, deodorant, toothpaste, toothbrush)
- O A reusable water bottle that is labeled with your name
- O Medications you will need for the whole retreat time
- O Clothes for Sunday Mass

NOTE: There will be *optional* water games on Saturday, so you may want to bring extra clothes if you intend to participate!

BLAST FROM THE PAST

Come on Saturday wearing your favorite retreat tee-shirt from past years!
Don't have one yet? We'll have some extras on hand ☺

SPRED SUMMER RETREAT RESPONSE FORM
PARTICIPANTS

Please return by **July 18, 2019** with payment;
(*Checks Payable to ARCHDIOCESE OF INDIANAPOLIS*)
Mail To: 1400 N Meridian Street; Indianapolis IN 46202
Contact Erin Jeffries at (317) 236-1448 or ejeffries@archindy.org for assistance

- **Full Retreat Registration ($75 shared room, $85 single room)**
- **Days Only (no overnight) ($10 per meal, $10 for a tee-shirt)**

Name: _____
Address: _____
Email: _____
Phone number: _____
Date of Birth: _____
T-Shirt Size: (Circle one) SM MED LARGE XL XXL Other (Specify) ___

_____

Emergency Contact Information ***(Please provide two contacts)***

(1) Name: _____
Relationship _____
Phone Number(s): 1. _____2. _____

(2) Name: _____
Relationship _____
Phone Number(s): 1. _____2._____

Medication/Dosage Instructions: ***Please use medication form provided***

ALL MEDICATIONS MUST BE CHECKED IN WITH THE NURSE

Food Allergies/Restrictions/Special Instructions: _____
_____

Assistance needed for: *(Please check all that apply and explain)*
Dressing ___ Toileting ___ Bathing ___ Medication ___ Meals ____
_____
_____
_____

PLEASE TURN FORM OVER →

What would you want someone new to know about you (the participant)?

_____
_____
_____
_____
_____
_____

Specific roommate request: _____

Particular staff/ attending needs:

o This person will have staff accompanying him/her

Staff Name: _____

Staff Contact Number: _____

Agency Emergency Contact Number: _____

Other: _____

_____

Other helpful information (routines, care needs, calming strategies, triggers, etc.)
Please include any recent significant life events or changes.

_____
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Who will pick up participant at the end of the retreat, 3PM on Sunday, August 11?

Name: _____ Phone #: _____

SPRED SUMMER RETREAT 2019
HEALTH FORM

Return all signed forms to:
Erin Jeffries
1400 N. Meridian Street
Indianapolis, IN 46202
ejeffries@archindy.org

Please Note:
Having adequate information about our participants is crucial to our ability to provide a safe and supportive environment.

For this reason, we cannot allow anyone to participate in the retreat without a completed health form.

Participant's Full Name: _____

Sex (circle one) male female Birthdate: ___/____/_____

Allergies: Check those that apply

- O No known allergies
- O Allergic to this food (s) _____
  Causes Anaphylaxis? YES NO
- O Allergic to this medication(s) _____
  Causes Anaphylaxis? YES NO
- O Allergic to the following:
  _____
  Causes Anaphylaxis? YES NO

Nutrition/Diet: Please note that we can work with some medically prescribed diets, but not necessarily individual food preferences. Please call if you have any questions.

- O Eats a regular diet
- O Vegetarian
- O Gluten free
- O Lactose intolerant
- O Other (please specify)
  _____

Chronic Health Concerns: Check those that apply

- O No chronic health concerns
- O Has the following chronic health concern (s)

  - O Asthma
  - O Headaches
  - O Sleepwalking
  - O Diabetes
  - O Menstrual cramps
  - O Frequent ear infections
  - O Fainting
  - O Incontinence
  - O Seizures
  - O Surgical history of consequence
  - O Other (describe below)

Information about the items above (attach additional info if needed): _____

_____

_____

_____

Medication: "Medication" is any substance a person takes to maintain and/or improve his or her health, including over the counter medications, vitamins and homeopathic remedies.

- O This person will not take any medications while attending the retreat
- O All medications the participant will take are listed on the attached form.

Note: ALL medication must arrive in the original appropriately labeled containers, and given to the nurse upon arrival. Please contact Erin Jeffries if you have any questions.

Mental, Emotional, Learning and Social Health: Check each statement that applies

- O This person has been diagnosed with a condition that impacts learning (e.g. ADHD, sensory processing problem, etc.)
- O This person has a mental health diagnosis such as depression, OCD, panic/anxiety disorder
- O This person has an emotional health concern (please specify) _____

Information about the items above (attach additional info if needed): _____

_____

_____

MEDICAL TREATMENT RELEASE

Archdiocese of Indianapolis Policy Statement 2008-02 recognizes that parents (guardians) have the primary responsibility for the health of their dependent Although it is strongly recommended that medication be administered at home, the health of some adults with disabilities may require that they receive medication or other medical care while in the care of the SPRED Retreat. This also applies to non-dependent adult participants.

If a medication must be taken while at the SPRED Retreat please be advised of the following:

- ✓ When medication absolutely must be taken at other times outside the home, parents (guardians) or non-dependent adult participant shall provide explicit written instructions including, in some cases, instructions as necessary from a medical practitioner regarding the need for medication or specific medical care.

- ✓ Parents (guardians) and non-dependent adults signing this form are, in most cases, providing written permission for volunteer nurses to oversee the **self-administration** of medication or necessary routine medical care **by the participant** depending upon age and capability.

- ✓ *Participants* are not permitted to carry or keep medications (including analgesics, herbs, enzymes, oils, etc.) on their person, ***except for inhalers or other medical devices with specific permission***. Medications will be secured during the retreat for the protection of all participants.

- ✓ If a participant has staff who in the normal course of their duties dispense or oversee self-administration of medication, ***the staff member may retain and secure that participant's medication.***

- ✓ All medication is to be delivered and taken home by the parent (guardian) or non-dependent adult at registration and at end of the retreat.

- ✓ All medication is to be taken in the presence of a volunteer nurses and documented in a confidential log.

- ✓ **No medication** of any kind is to be provided by the SPRED Retreat staff or volunteer nursing personnel.

- ✓ Prescription medication must be in the original pharmaceutically dispensed and labeled container. The prescription label will be considered the written order of the medical practitioner in most cases.

- ✓ Non-prescription medication must be in the original container in which it was purchased. Please provide medicine cups/spoons as necessary for liquid medication.

- ✓ If a staff person will be retaining and overseeing the medication of a participant, the SPRED retreat staff will still be provided with a list of that participant's medications.

Permission to Participate and Appointment of Agent

CONSENT

I hereby consent for _____ to participate in The SPRED Summer Retreat from August 10-11, 2019.

I acknowledge that I have received information about the program and consent to his or her participation.

WAIVER AND RELEASE

I release and waive, and further agree to indemnify, hold harmless or reimburse the *Archdiocese of Indianapolis*, its successors and assigns, its members, agents, employees, and representatives thereof, as well as volunteer mentors, from and against, any claim which I, any other parent or guardian, any sibling, the participant, or any other person, firm or corporation may have or claim to have, known or unknown, directly or indirectly, from any losses, damages or injuries arising out of, during or in connection with the above named individual's participation.

I hereby authorize a representative of the *SPRED Summer Retreat Staff* as my agent. My agent may consent to the above-named participant's: transportation by ambulance, examination, x-rays, diagnosis, hospitalization, anesthesia, medication and any emergency medical treatments that are necessary in the best judgement of the healthcare providers.

Participant Name: _____

Parent/Guardian Name (if applicable): _____

Address: _____

Phone: (H) _____ (C) _____ E-mail: _____

Participant Date of Birth: _____

Name of Heath Insurance Company: _____

Policy Number: _____

_____ _____

Signature of Parent/Guardian or Non-Dependent Participant Date