



FAITH'S LODGE

GUEST APPLICATION FORM FOR FAMILIES COPING WITH A CHILD'S SERIOUS ILLNESS

To provide you with the best possible experience at Faith's Lodge, your application must be filled out completely. Please be assured that all information will remain confidential and is being used solely for informational purposes. We regret that we will be unable to review and process incomplete applications. A \$25 non-refundable application fee must accompany your guest application. Please call 715-866-8200 if you have any questions.

Please indicate your preferred dates of stay: *You may select any number of nights, from one to five, within your preferred time frame.*

(1) _____ (2) _____ (3) _____

Please refer to our on-line guest calendar for available dates. The cost to stay at Faith's Lodge is \$25 per night. Scholarship options are available.

Person completing this application: _____

Person who referred you to Faith's Lodge: _____ *(name and occupation/relationship)*

How did you learn about Faith's Lodge: _____

Child's Name: First _____ Last _____

Date of Birth _____ Sex _____ Age _____

Family Members Staying at Faith's Lodge:

Mother's Name: First _____ Last _____

Father's Name: First _____ Last _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

E-mail address _____

Name(s) and age(s) of all your other children who will be staying at Faith's Lodge:

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Do any of your children have an IEP (individualized education plan)? If yes, please explain. _____

Emergency Contacts:

Name _____ Address _____

Home Phone _____ Cell Phone _____

Name _____ Address _____

Home Phone _____ Cell Phone _____

Hospital where child is being treated _____

City _____ State _____

Attending Physician _____ Physician Phone Number _____

Physician E-Mail and/or alternate contact: _____

Please describe your child's illness and any special medical needs or considerations: *(For example, the child is confined to a wheelchair, uses oxygen, etc.)* **Please be aware that Faith's Lodge is handicapped accessible, but not equipped to support other medical needs.**

Describe any concerns that you or your spouse/partner have now relating to your child's ability to cope effectively:

Describe any concerns that you or your spouse/partner have relating to your other children or any concerns that you've heard them express relating to their sibling's condition: _____

How would you describe your family's communication regarding your child's illness:

Open Adequate Very Little Avoided None Desire More

Does anyone else in your family have any health problems or allergies that we should be aware of? If so, please explain. _____

Is anyone in your family currently taking any prescription medication? If so, please list the name of the medication and the person taking it. _____

Please tell us about any special interests or hobbies: _____

What are your expectations or hopes for your stay at Faith's Lodge? _____

Is there anything else that you would like to share that will allow us to better serve you as guests of Faith's Lodge? _____

Every effort will be made to honor your requested date of stay; however, space is limited. Applications are processed in the order received and all information is confidential.

I/we understand and recognize staying at Faith's Lodge is contingent on approval of this application as well as compliance with all conditions, qualifications and restrictions designated by Faith's Lodge.

Signature _____ Date _____ Signature _____ Date _____

Once your registration form is complete you may send it via e-mail to enyberg@faithslodge.org or mail it to: Evelyn Nyberg, Lodge Manager, Faith's Lodge, 6942 County Road C, Danbury, WI 54830. We look forward to welcoming you to Faith's Lodge and hope you will have memorable together times, lots of fun, and will leave feeling refreshed mentally and physically.



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MEDICAL ASSESSMENT *(To be completed by physician)*

Name of physician completing assessment *(Please print)* _____

Hospital _____

Phone _____ Fax _____

Diagnosis of child _____ Date of Diagnosis _____

Is this condition considered ___life threatening ___life long ___short life expectancy ___chronic?

Is the child undergoing continued treatment for this illness? If so, how often? _____

What treatment is the child undergoing? _____

If treatment has ended, when was the last date of treatment? _____

How often is the child seen for their condition? _____

Date of last visit _____

I have explained the child's medical condition to the parent(s) and have instructed parent(s) on how to handle emergencies for the child's specific illness. As long as parent(s) take sufficient precaution to protect patient in accordance with physician's instruction, there is no medical contraindication to patient's visiting Faith's Lodge or participating in programs offered by Faith's Lodge.

Physician's Signature _____ Date _____

REFERRAL SOURCE ASSESSMENT

Name and title of person completing assessment _____

Organization _____ Phone _____

___I fully understand what will be available to families at Faith's Lodge.

___I have discussed in detail with this family what Faith's Lodge has to offer.

Comments _____

Signature _____ Date _____