

## Application for Families Coping with a Child's Serious Illness



**FAITH'S LODGE**

*a place where hope grows*

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 \$35 non-refundable 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 the online guest calendar for available dates. The suggested minimum donation to stay at Faith's Lodge is \$35 per room per night. Scholarship options are available.**

Person completing this application: \_\_\_\_\_

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

Child's First Name \_\_\_\_\_ Child's Last Name \_\_\_\_\_

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 \_\_\_\_\_

Work Phone (father) \_\_\_\_\_ Work Phone (mother) \_\_\_\_\_

E-mail address \_\_\_\_\_

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

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ 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 scan and e-mail it to [enyberg@faithslodge.org](mailto:enyberg@faithslodge.org) or mail it to:

Ev Nyberg  
Manager of Lodge Operations  
Faith's Lodge  
6942 County Road C  
Danbury, WI 54830

*We look forward to welcoming you to Faith's Lodge, and hope it will be a haven that allows you and your family to relax, reconnect and continue your healing journey.*

# Faith's Lodge Medical Assessment



**FAITH'S LODGE**

*a place where hope grows*

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 \_\_\_\_\_

## Faith's Lodge Referral Assessment

Each couple and family that expresses an interest in visiting Faith's Lodge must receive a referral from a member of their healthcare team or faith community, a mental health professional or an approved support organization, such as the Ronald McDonald House.



**FAITH'S LODGE**

*a place where hope grows*

Please fill out this form completely to facilitate the application process. If you have not spoken with a staff member prior to making this referral, you will be contacted once the application is received.

Name and title of person completing assessment \_\_\_\_\_

Organization \_\_\_\_\_ Phone \_\_\_\_\_

Name of child \_\_\_\_\_

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 \_\_\_\_\_

Please note: A **\$35 non-refundable application fee must accompany each guest application.** The suggested minimum donation to stay at Faith's Lodge is \$35 per room per night for first-time guests. There is a \$95 fee per room per night for all return guests.