Order of Malta International Summer Camp 2024

August 11- 18, 2024 | Fiesch, Switzerland

Maltacamp 2024
Switzerland Liechtenstein

Federal Association Guest Application for ISC 2024
Submission Deadline is March 20th, 2024

Submission Instructions: Please email this completed application to both richamena@gmail.com and FederalAuxiliary@gmail.com
Please direct any questions to Richard A. Mena at richamena@gmail.com

Applications must be received by March 20th, 2024.

PERSONAL INFORMATION

Guest Name: ____
Last First MI

Date of Birth: ___/____/_____ Age: _____

Home Address: ____

____

Primary Phone:____________________ E-Mail: __________________________

Primary Diagnosis: ______________________________________

Secondary Diagnosis: ____________________________________

Primary Care Physician: __________________________________

Primary Care Physician Contact Information:

Phone Number:____________________Email: ______________________________

Date of last Physical: ____________________

I require one-on-one support and would need to bring an Aid if selected:
Yes____No ____

Name of Aid: ____
Last First MI

Aid Agency or relationship to guest: ___________________________

Aid Contact Information:

Address:____

____

Phone:_______________ Email:__________________

Emergency Contact Information

Name of primary contact:_____________________________
Relationship to Applicant: ____________________________
Primary Contact Phone number: _________________________
Primary Contact Email Address: _________________________

Name of Secondary Contact: ___________________________
Relationship to Applicant: ____________________________
Secondary Contact Phone Number: _______________________
Secondary Contact Email Address: _______________________

HEALTH INFORMATION

1) Please list all allergies (such as skin, food, olfactory, etc.)

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2) Please list any health conditions, which may require EMERGENCY ACTION, such as Seizures, Asthma, Heart problems, Diabetes, Insect sting allergies, Hemophilia, Heat exhaustion, etc.

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3) Please check which joints have limited or no range of motion.

Neck or Spine: _________			Hips	____Left	___Right
Shoulders	___Left	___Right	Knees	____Left	___Right
Elbows	___Left	___Right	Ankles	____Left	___Right
Wrists	___Left	___Right	Toes	____Left	___Right
Fingers	___Left	___Right			

Which body parts CANNOT be moved, and why?

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4) Please note any sense impairments which the team should be aware of when interacting (ex, Difficulty hearing in one or both ears, Vision, etc.)

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5) Please list all necessary assistive devices such as glasses, hearing aids, communication devices, CPAP Machine, Monitors, orthotic device (I.e. braces), crutches, or wheelchair.

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ACTIVITY INFORMATION

1) Check any activities that are contraindicated (not allowed).

Kneeling ___

Sitting on Floor ___

Moving/Flickering Lights ___

Stretching Body Parts ___

Climbing ___

Heights ___

Massage with Oils _____

Massage with Vibration _____

Tactile Stimulation (feathers, brushing, etc) _____

High-pitched Sounds _____

Swimming _____

Being around animals Dogs, Cats, Farm animals, Zoos) _____

2) Please describe the precautions to be taken before participating in an outdoor activity:

____

____

____

3) Please describe what, if any assistance the guest may require with the following activities:

Activity	Self- Sufficient	Needs Assistance (List assistance required)
Eating/ Drinking		
Bathing		
Toilet		
Grooming (Shaving, brushing, Teeth, etc)		
Dressing		
Stairs		

COMMUNICATION INFORMATION

1) Check all forms of communication that apply:

Verbal _____ Body gestures _____ Facial Gestures _____

Other:__

2) Please describe how the guest expresses him/herself in each situation:

Situation	Response
Pain/Discomfort	
Anxiety	
Over- Stimulation	
Happiness	

Saying “Yes” to a question	
Saying “No” to a question	

BEHAVIORAL INFORMATION

1) Please list all the behaviors that may need special attention and how to manage each specific behavior:

Behavior	**Management Technique**
Example: Screaming	*Allow a break from the activity*

2) Please list all guest’s likes and dislikes which should be known:

Likes	**Dislikes**

NUTRITION INFORMATION

1) Please list all food restrictions to be considered during the camp (I.e. gluten- free, low-fat, etc.)

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2) If accidentally consumed, what is the anticipated result and what if any treatment or action is necessary? (ex. Medication, Rest, Epi-pen, etc.)

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3) Is guest permitted to consume alcohol?______Yes _____No
(There will be alcohol present at some camp activities, but no guest or volunteer will be required, pressured, or encouraged to consume alcohol.)

COVID 19- We anticipate that the camp will proceed under the requirements imposed by Switzerland for entrance to the Country at the time of the camp. Currently Switzerland does not require proof of vaccination to enter. Of course, as with all health situations, things can change, and updates may be necessary. We will keep guests' families informed of any updates as they become available.
In order to best understand how any requirements may impact the guest's ability to participate, please let us know the following:

1. Has the guest had COVID-19? If so, please describe when (month and year,) and provide any relevant details.____

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2. Please list any comorbidities or pre-existing conditions which might make the guest more susceptible to COVID-19 or to a more severe impact from the COVID-19 virus. ____

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3. Has the guest received a COVID-19 vaccination? If so, which vaccination, when was it received (if one that requires two doses, have both been administered)? Has the guest received a booster? If so, which booster and when was it received?____

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4. If guest has not received the COVID-19 vaccination, do they intend to get vaccinated? Does the guest have a scheduled date for the vaccine?__________

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5. Does the guest have any difficulties or apprehensions about using current COVID-19 safety methods where required such as wearing protective masks, washing hands frequently, maintaining safe distance from others, and having their temperature taken? If so, please explain. ___________________________

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6. Does the guest have the ability to recognize and communicate if they are not feeling well or are suffering from potential symptoms of COVID-19? (fever, difficulty breathing, fatigue, cough, aches, headache, **loss of taste or smell,** sore throat, congestion, nausea). ___________________________

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7. Is the guest able to undergo testing for Covid 19 (PCR test, Antigen test)

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ADDITIONAL INFORMATION:

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To my knowledge, all information in this application is accurate and up-to-date.

__________________________ ______________________________ ____________
Signature Relationship/ Authority Date

Please email this completed application to richamena@gmail.com and FederalAuxiliary@gmail.com by March 20th, 2024