2025 VACATIONER PROFILE

The Arc of Lincoln PO BOX 57002, Lincoln, NE 68505
402.421-8866| director@arclincoln.org

ALL SECTIONS MUST BE COMPLETED TO BE SIGNED UP FOR TRIP(s)

ABOUT THE VACATIONER

Vacationer's Name (first, middle, last)_____

Address:_____

City/State/Zip_____ **DOB:**_____ **SS#:**_____

Form Completed By Name: _____

Name: _____

Address: _____**City/State/Zip**_____

Phone: _____ **Email:**_____

Insurance Company: _____ **Policy #** _____

Insurance Company Address: _____

Insurance Company Phone: _____

Vacationer's Strengths: _____

Vacationer's Interests:

_____

Vacationer's Needs/Disability/Diagnosis:

_____

DIETARY LIMITATIONS

Describe restrictions or special diet (Please note that these should be medically related as this is a vacation and sponsors will not struggle with the vacationer over food choices that are not part of a medical condition.)

_____

Favorite foods:

_____

Disliked foods:

_____

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GENERAL CARE INFORMATION

Communication: Please check.

( ) Verbal ( ) Nonverbal ( ) Uses American Sign Language ( ) Uses own signage ( ) Uses communication device: If so, which device:

_____

Understands and follows directions: ( ) Yes ( ) No If no, please explain:

_____

Describe communication/speech abilities and needed strategies:

_____

Vision:( ) Wear glasses/contacts ( ) Uses magnifiers ( ) Uses Technology for Vision Support ( ) Other
Describe vision abilities and needed strategies:

_____

Hearing: ( ) Uses hearing aids/devices ( ) Uses Cochlear Implant
Describe hearing abilities and needed strategies:

_____

Ability to Read: ( ) Yes ( ) No Ability to Write: ( ) Yes ( ) No

LODGING/ROOM NEEDS

Wheelchair accessible room required? ( ) Yes ( ) No

Roll-in shower required? ( ) Yes ( ) No

Share room w/ other vacationer (w/o sponsor):
( )Required ( )Preferred ( ) Not Preferred

Preferred Roommate: Already discussed w/ roommate? ( )Yes ( )No

Roommate Name:_____ **Phone #:** _____

Prefers Own Room ( ) Yes ( ) No (availability & additional charges will apply)

MEDICAL INFORMATION

Incontinence: ( ) Bladder ( ) Bowel ( ) Uses Depends ( ) None Please explain:

_____

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Current Tetanus shot? ( ) Yes ( ) No Date:

_____

Allergies? ( ) Yes ( ) No Please list:

_____

Asthma? ( ) Yes ( ) No Please explain:

_____

Communicable Diseases? ( ) Yes ( ) No Please list:

_____

Seizures? ( ) Yes ( ) No Type: _____ Frequency: _____ Triggers: _____ **Diabetes?** ( ) Yes: uses insulin ( ) Yes: does not use insulin ( ) No

Accurately reports illness? ( ) Yes ( ) No Please explain:

_____

Tendency for infections:	( )Yes	( )No	**Tendency for colds:**	( )Yes	( )No
NoTendency for constipation:	( )Yes	( )No	**Tendency for diarrhea:**	( )Yes	( )No
Tendency to sunburn:	( )Yes	( )No	**Tendency to sunstroke:**	( )Yes	( )No
Tendency for earaches:	( )Yes	( )No	**Tendency for rashes:**	( )Yes	( )No
Tendency for stomach aches:	( )Yes	( )No	**Tendency for fevers:**	( )Yes	( )No

Comments:_____

MEDICAL INFORMATION- MEDICATIONS: Please list all medications taken in the chart at the end of this Profile.....

Over the counter medication allowed:

Aspirin:	( )Yes	( )No	**Antacid:**	( )Yes ( )No	**Decongestant:** ( )Yes ( )No
Tylenol:	( )Yes	( )No	**Constipation Assistance:**	( )Yes	( )No
Cold/Flu:	( )Yes ( )No		**Diarrhea Control:**	( )Yes	( )No
Cough Syrup:	( )Yes	( )No	**Motion Sickness:**	( )Yes ( ) No	

Other over the counter medication NOT allowed:

_____

Sponsor is to administer all medications: ( )Yes ( )No

Vacationer needs reminders when to take medications: ( )Yes ( )No

Vacationer is responsible for taking all medications (no assistance from sponsor): ( )Yes ( )No

Vacationer takes medication with water: ( )Yes ( )No Other: _____

Vacationer has difficulties taking medications: ( ) Yes ( ) No Please explain:

_____

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MONEY MANAGEMENT

All money to be held by sponsor (spending will be recorded and receipts will be kept):( )Yes ( )No
All money to be held by vacationer (vacationer responsible for spending choices and receipts): ( )Yes ( )No
Spending suggestions:

_____

Vacationer's T Shirt Size: ( ) Small ( ) Medium ( ) Large ( ) X-Large ( ) XX-Large ( ) 3XL Other _____

MOBILITY SKILLS

Walking Ability:	( )Limited	( )Minimal	( )Moderate	( )Extensive
Needs assistance walking?	( )Yes	( )No		
Coordination:	( )Weak	( )Average	( )Strong	
Uses a manual wheelchair?	( )Yes	( )No		
Uses an electric wheelchair?	( )Yes	( )No		
Wheelchair lift to access vehicles required?	( )Yes	( )No		
Transfers to a vehicle seat on own?	( ) Yes	( )No		
Transfers to the toilet on own?	( )Yes	( )No		
Tires easily?	( )Yes	( )No		
Uses walking aids?	( )Yes	( )No		
Uses an elevator?	( )Yes	( )No		
Uses stairs?	( )Yes	( )No		
Uses Escalator?	( )Yes	( )No		

Comments- Please describe specific Mobility needs and needed assistance with Mobility:

_____

RECREATIONAL ACTIVITIES

Ability to Swim: ( )Yes ( )No
Needs Life Jacket: ( )Yes ( )No
Comments about recreational water activity:_____
Smokes:( )Yes ( ) No **Brand/Type:** _____ **Frequency:** _____

SELF CARE SKILLS Please check and write notes as needed

Bathing: ( )Independent ( )Reminders Only ( )Needs Assistance:

_____

Daily Care: ( )Independent ( )Reminders Only ( )Needed Assistance:

_____

Needs Daily Care Assistance with:

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( )Dental Care ( )Deodorant ( )Feminine Hygiene ( )Hair Care ( ) Shaving ( ) Sunscreen

Dressing: ( )Independent ( )Reminders Only ( )Needed Assistance:

_____

Needs Dressing Assistance in selecting daily clothing? ( )Yes ( )No
Needs Dressing Assistance/Prompts to change clothes daily? ( )Yes ( )No

Toileting: ( )Independent ( )Reminders Only ( )Needs Toileting Assistance
Explain: _____

Other Comments- Please be specific describing needed assistance with Self Care:

_____

_____

SUPPORTS for BEHAVIOR/EMOTIONAL NEEDS.....

Behavior/Emotional Strengths: Please note-

_____

Cooperative: ( )Yes ( )No **Makes Independent Decisions:**( )Yes ( )No
Interacts appropriately with: ( ) Staff ( ) Peers ( ) Opposite Sex ( ) Strangers ( ) Children ( ) Animals

Behavioral/Emotional Needs:

Prone to Stealing:	( )Yes ( )No	**Inappropriate Touching**:	( )Yes ( )No
Sleep Disturbances:	( )Yes ( )No	**Excessive Anxiety**:	( )Yes ( )No
Aggressive Towards Others:	( )Yes ( )No	**Destructive of Property:**	( )Yes ( )No
Self-Injurious:	( )Yes ( )No	**Needs personal space**:	( )Yes ( )No
Fabricates Stories:	( )Yes ( ) No	**Overly- friendly**:	( )Yes ( )No
Prone to Excessive Talking:	( )Yes ( )No	**Argumentative:**	( )Yes ( ) No
Prone to Wander Off:	( )Yes ( )No		

Please explain wandering:_____

For any Yes answers, please make comments on how to best redirect and or support the vacationer.

Comments:_____

_____

_____

Please describe situations that provoke anger, frustration, or negative behaviors and how to support these situations:

_____

_____

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Situations that may cause over stimulation:

Fears or phobias:_____

Adverse reactions to loud noises, lights, crowds, etc:

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MEDICATION APPENDIX: REQUIRED……

All medication must be pre-packaged in individual doses (all morning medications in the same package for each day, all evening medications in the same package for each day. Each package must be labeled with the vacationer's name, date, & time of dosage. Packing an additional day of medication is recommended. The following medication schedule must be completed for all prescription & nonprescription medications:

Example: Vytorin	*1mg 3 times a day*	*8am, noon, 3pm*	*Cholesterol*	*May cause drowsiness*
Medication Name	**Dosage**	**Times**	**Purpose**	**Side Effects/ Special Instructions**