

DREAM Program, Inc.



Individual Trip Application Form

Name of Participant: _____

Have you been on a DREAM trip before? Y N What trip: _____

Address: _____

Phone: _____ email: _____

Parent/Guardian/Care Provider (if applicable): _____

Please describe the diagnosis/disability of the participant: _____

- Cognitive deficits? Y N _____
- Use a wheelchair? Y N _____
- Currently in treatment? Y N (Circle one) Psycho-social/behavioral, mental illness, substance dependency, other: _____

Please choose your top two trip dates and we will try to reserve the date you are interested in: *Note: Trips are reserved on a first come, first serve basis.*

Canoeing Day Trip/

June 19th, 2010

July 17th, 2010

August 21st, 2010

September 18th, 2010

What are your goals for this program? _____

Please describe any special circumstances that you feel we need to know about

For office use only: Eligible for trip? Y N

Trip dates: _____

___ packet/letter sent ___ waiver and release ___ Medical release forms

___ lifestyle/behavior assessment ___ disability information