



2012 YACHAD MIDWEST FAMILY SHABBATON APPLICATION

PARENT/ GUARDIAN INFORMATION (ONLY THOSE ATTENDING)

If you live outside the Chicago area please check

Mother 's First Name: _____ Last Name: _____

Father's First Name _____ Last Name: _____

Email: _____ Cell #: _____ Home #: _____

Current address: _____

City: _____ State: _____ ZIP Code: _____

Name (s) of child(ren)/adult (s) with disability : _____ Ages: _____
(Fill out their information on page 4)

Please List all Non Married Children Attending :

_____ Age: _____ _____ Age: _____

_____ Age: _____ _____ Age: _____

_____ Age: _____ _____ Age: _____

OTHER RELATIVE INFORMATION (ONLY THOSE ATTENDING)

First Name: _____ Last Name: _____

Spouse First Name: _____ Last Name: _____

Relationship (to individual with disability): _____ Age: _____

Email: _____ Phone #: _____ Cell #: _____

Current address (if different than above): _____

City: _____ State: _____ ZIP Code: _____

List children attending:

_____ Age: _____ _____ Age: _____

_____ Age: _____ _____ Age: _____

First Name: _____ Last Name: _____

Spouse First Name: _____ Last Name: _____

Relationship (to individual with disability): _____ Age: _____

Email: _____ Phone #: _____ Cell #: _____

Current address (if different than above): _____

City: _____ State: _____ ZIP Code: _____

List children attending:

_____ Age: _____ _____ Age: _____

_____ Age: _____ _____ Age: _____

For internal use only:

Family Number: _____



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ROOMING REGISTRATION

PLEASE FILL OUT ACCORDING TO HOW MANY ROOMS YOU WILL BE OCCUPYING

Please understand that we will do our best to accommodate requests, but they cannot be guaranteed.

How many rooms do you need? _____ (You will be charged double occupancy for each room)

All Rooms at our hotel come equipped with a refrigerator

If your infant/toddler is not able to sleep in a bed, please bring a pack-in-play along with you as the hotel does not provide this. Please be in touch with us, if this presents a significant difficulty.

Room 1	King Bed _____	Double Bed _____	No Preference _____	Adjoining room _____
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Names of people staying in the room:

Person 1

Person 2

Person 3

Person 4

Please Check if you will need the following:

Cot

Room 2	King Bed _____	Double Bed _____	No Preference _____	Adjoining room _____
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Names of people staying in the room:

Person 1

Person 2

Person 3

Person 4

Please Check if you will need the following:

Cot

Room 3	King Bed _____	Double Bed _____	No Preference _____	Adjoining room _____
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Names of people staying in the room:

Person 1

Person 2

Person 3

Person 4

Please Check if you will need the following:

Cot



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PAYMENT

(PLEASE INCLUDE FEE FOR YACHAD MEMBER HERE ALONG WITH THE REST OF YOUR FAMILY, ACCORDANCE WITH THE APPROPRIATE AGE CATEGORY)

Adults at \$195.00 per person (based on double occupancy) (Anyone 19 years old and above is considered an adult)	# _____ X \$195.00 =	\$ _____
Teenagers (12-18) at \$125 each	# _____ X \$125.00 =	\$ _____
Children (6-11) at \$75.00 each	# _____ X \$75.00 =	\$ _____
Children 0-5 FREE	# _____ X FREE =	\$ <u> 0 </u>
	TOTAL:	\$ _____

Please don't hesitate to call if a scholarship is needed

Payment Method:

Enclosed Check VISA Master Card AMEX

Credit Card #: _____

Exp. Date: _____

Signature: _____

Send a bill

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

<p>Please note any other additional requests:</p> <p>_____</p> <p>_____</p> <p>_____</p>
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PERSON WITH DISABILITY (YACHAD MEMBER) REGISTRATION

Please print and fill out a separate sheet for each Yachad member coming to the Shabbaton

FIRST NAME: _____ LAST NAME: _____

BIRTHDATE: ___/___/___ Age: _____

A. PLEASE ANSWER THE FOLLOWING QUESTIONS:

1) Where will the YACHAD member be sleeping on this Shabbaton?

- In a room with other Yachad members and Yachad staff with parents, or another family member

2) Any Allergies? YES NO IF YES: (please list) _____

3) Will any medication need to be administered? YES NO

4) Will assistance be needed for medication administration? YES NO

B. PLEASE FILL OUT THE CHART BELOW:

NAME: (specific name of the medication)	TIME GIVEN:			DOSAGE: (Amount of...)	DESCRIPTION: (Size, Shape, Color)	PURPOSE: (Why is the medication given?)	Procedure to follow if medication is missed
	Morn/Afternoon /Evening						

(Please add another sheet if necessary)

C. PLEASE CHECK OFF ALL THAT APPLY:

- Needs assistance getting dressed Needs assistance eating Needs help with physical activity
 Needs assistance with grooming Needs assistance with mobility; Please specify _____
 Other areas of assistance: _____

The following techniques are helpful in working with my child (i.e. transition warnings, positive reinforcements, visual cues, behavior modification):

I would like the staff to consult me before they act on the following issues/situations:

D. Person completing form: _____ Relationship to participant: _____

- I will assume responsibility for my child (YACHAD member) during Family Shabbaton
 I would like to coordinate responsibility for my child (YACHAD member) with YACHAD staff

Applicant's signature: _____



YACHAD

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SPONSORSHIP OPPORTUNITY

The cost for this weekend is highly subsidized by Yachad.
Please become a sponsor and help another family join our Shabbaton.

- _____ \$500 Platinum
- _____ \$360 Gold Silver
- _____ \$180 Silver Gold
- _____ \$100 Bronze
- _____ Other (any amount will help)

This donation is in *honor* or *memory* (circle one) of



YACHAD

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MEAL SEATING

If you have a request for who you would like to sit with at meals, YACHAD will try its best to honor those requests.

Name of Family, or families, you would like to sit with: _____

Thank you in advance for your support!