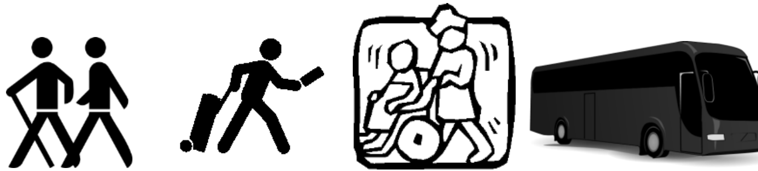

Mission: **LOGAN COUNTY VETERANS TO WASHINGTON D.C.**

TRAVEL COMPANION APPLICATION

The "Mission to DC" trip wouldn't be successful without the support of our Volunteers. They play a significant role in ensuring the safety and welfare of our Veterans. Additionally, the Travel Companion duties are just as important. Our Veterans look to you to provide care, companionship and help as needed during our trip. We attempt at all costs to make this as memorable as possible for our Veterans. This trip is about them! It is not about you/us. It is very important that our Travel Companions and Volunteers remember that. If you anticipate a personality conflict, we ask that you perhaps forego this trip. Taking the spotlight away from the Veteran will not be tolerated.

All companions must stay in the same room as the Veteran they are attending the trip with. If this may be a problem call Scott Stewart @ 937-407-6766.

Travel Companions and Volunteers are responsible to pay their own way. This cost is $250 and will be due prior to travel.

Please do not send payments with the application. **You will be given instructions for payment once you are approved for the trip.**

Name: ____________________________ Nickname: ____________________________

Veteran you are traveling with: __________________________ Relation to Vet: ______________

Street Address: ____

City, State & Zip:____

Home phone:________________________ Cell phone: ____________________________

E-Mail: ____

Alternate Contact:

Name: ____________________________ Relationship:____________________________

Home Phone: __________________________Cell Phone: ____________________________

E-Mail Address:____

Shirt size: (Men's shirt sizes) S M L XL XXL XXXL 4XL 5XL (Circle one)

Medical Information: In order for us to plan and better serve you, we must ask a host of medical questions. Although they may seem intrusive, these questions are asked in order for our nurses to anticipate your health needs, and for us to plan for your volunteer assignment. Additionally, we ask that your physician be made aware of your travels in order for us to be able to plan for your care in the event of any unanticipated events, should they occur away from home. ***Please be as thorough as possible, and rest assured that this will not disqualify you from going.*** We anticipate that with age,

we will have health issues. With that said, you will need to be able to climb up and down a short flight of stairs, going in and out of the buses that carry us to our destinations.

IT IS STRONGLY RECOMMENDED THAT YOU DISCUSS THIS TRIP WITH YOUR PHYSICIAN ESPECIALLY IF YOU HAVE SIGNIFICANT HEART OR LUNG ISSUES.

Dr. Name & Phone Number: ____

Do you have a problem with motion sickness? (circle one) Yes No
If yes, can this be controlled with medication? (circle one) Yes No

Weight: _______________________

Do you have any problem with walking the length of a football field unassisted? (circle one) Yes No
(This will not disqualify you for the trip)

Reason for difficulty with walking: Lungs Heart Pain Other:___________________________________

Do you normally use a: (circle all that apply) Cane Walker Wheelchair Scooter
Wheelchairs will be provided for those in need.

Do you use: (circle all that apply) CPap Machine Nebulizer Oxygen
If Oxygen is being used, we must have a written prescription from your physician, turned in with your application.

Do you have any Drug Allergies: Yes No
If yes, please list: ____

Do you have a history of?
Heart Issues: (such as Heart attack - List when and any treatment such as defibrillator or pace maker insertion)______________________

____

Stroke: (Please give details)____

Lung Issues: (i.e. COPD, Asthma)____

Asthma: (circle one) Yes No Recent Asthma Attack? ____

Seizure Disorder: (circle one) Yes No Last Seizure: ____

Diabetes: (circle one) Yes No Controlled by: (circle all that apply) Insulin Oral Hypoglycemic Diet

Auto Immune Disorders/ Arthritis: ____

Any other significant health history or surgeries that we should know about?__________________________________

____

____

____

____

____

Medications List:

Name of Medication	How often	Reason	Pharmacy

PLEASE SEND COMPLETED APPLICATION TO: VETERANS TO D.C. - PO Box 516 - DeGraff, Oh 43318

Any questions, please Email logancountyvetstodc@gmail.com or call Scott Stewart @ 937-407-6766

As a Volunteer, do you have a special talent that you might be able to provide to our group?

Would you be interested in?

______ Provide personal companionship ______ Help serving meals

______ Help with securing supplies ______ Help with fundraisers

______ Help with Chase Vehicle ______ Help with nursing services

______ Help setting up flags ______ Help with parking cars

______ Help with Mail Call ______ Help with securing escort

Any other services that you may offer?____

____

ACCIDENT WAIVER AND RELEASE OF LIABILITY FORM

I HEREBY ASSUME ALL OF THE RISKS OF PARTICIPATING IN ANY/ALL ACTIVITIES ASSOCIATED WITH THIS EVENT, including by way of example and not limitation, any risks that may arise from negligence or carelessness on the part of the persons or entities being released, from dangerous or defective equipment or property owned, maintained, or controlled by them, or because of their possible liability without fault.

I certify that I am physically fit, have sufficiently prepared or trained for participation in this activity, and have not been advised to not participate by a qualified medical professional. I certify that there are no health-related reasons or problems which preclude my participation in this activity.

I acknowledge that this Accident Waiver and Release of Liability Form will be used by the event holders, sponsors, and organizers of the activity in which I may participate, and that it will govern my actions and responsibilities at said activity.

In consideration of my application and permitting me to participate in the activity, I hereby take action for myself, my executors, administrators, heirs, next of kin, successors, and assigns as follows:

(A) I WAIVE, RELEASE, AND DISCHARGE from any liability, including but not limited to, liability arising from the negligence or fault of the entities or persons released, for my death, disability, personal injury, property damage, property theft, or actions of any kind which may hereafter occur to me including my traveling to and from this activity, THE FOLLOWING ENTITIEWS OR PERSONS: Logan County Vets to D.C. and/or their directors, officers, employees, volunteers, representatives, and agents, and the activity holders, sponsors, and volunteers;

(B) INDEMNIFY, HOLD HARMLESS, AND PROMISE NOT TO SUE the entities or persons mentioned in this paragraph from any and all liabilities or claims made as a result of participation in this activity, whether caused by the negligence of release or otherwise.

These risks are not only inherent to participants, but are also present for volunteers.

I hereby consent to receive medical treatment which may be deemed advisable in the event of injury, accident, and/or illness during this activity.

I understand while participating in this activity, I may be photographed. I agree to allow my photo, video, or film likeness to be used for any legitimate purpose by the activity holders, producers, sponsors, organizers, and assigns.

The Accident Waiver and Release of Liability Form shall be construed broadly to provide a release and waiver to the maximum extent permissible under applicable law.

I CERTIFY THAT I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND ITS CONTENT. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A CONTRACT AND I SIGN IT OF MY OWN FREE WILL.

______________________________	__________	______________________________	__________
Participant's Signature	Date	Participant's Name (Please print legibly)	Age

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Any questions, please Email logancountyvetstodc@gmail.com or call Scott Stewart @ 937-407-6766.