

**Application Deadline:  
May 11th  
2012**

**This is a once in a lifetime retreat weekend providing structured family-centered activities offering respite, relaxation, and recreation for families who have children with an autism spectrum disorder or related disabilities.**

**The Cervený Conference Center (www.campweed.org) is located in Live Oak, Florida on 500 acres of natural beauty. Its rustic surroundings make it an ideal setting for relaxing, recreation, and spending time with family and new friends.**

**The weekend is at no cost to the family (lodging, activities, and group meals included).**

**For more information see the attached flyer or email [marlena.fuller@jax.ufl.edu](mailto:marlena.fuller@jax.ufl.edu)**



**DELIVER  
the Dream**

**Event Date**

**June  
22 - 24**



# Family Retreat

## 2012 Application



Thank you for your interest in Deliver the Dream, a free weekend retreat for families who have a child or parent with a serious illness or crisis. Please read further for information on our program and the application process.

### Eligibility:

- Families must fit the illness or crisis criteria listed below.
- Families must have children between the ages of 0-18 years old living in the household.
- Family members attending must be living in the household of the applicant.
- Families **must** commit to attending the entire weekend from Friday at 11:30am until Sunday at 2:30pm.
- Families must participate in all scheduled activities.
- Families must be able to provide their own transportation to and from the venue.
- Families can not attend more than once.

### The following forms must be completed and returned before your application can be processed:

- Completed application (pages 3-5)
- Applicant Medical History & Health Examination (pages 6-7 ) *\*portion to be filled out by a physician\**
- Family Medical & Emergency Information (pages 8-10 )
- Releases for Publication, Travel, Participation & Claims (page 11)

Group Served	Date	Location	Application Deadline
Families who have a child with sickle cell	February 3-5	FFA Leadership Training Center Haines City, Florida	January 3 <sup>rd</sup>
Families who have a parent with multiple sclerosis	March 2-4	FFA Leadership Training Center Haines City, Florida	February 2 <sup>nd</sup>
Families who have a child with craniofacial conditions	April 20-22	FFA Leadership Training Center Haines City, Florida	March 20 <sup>th</sup>
Families who have a child with down syndrome	May 18-20	FFA Leadership Training Center Haines City, Florida	April 18 <sup>th</sup>
Families who have a child with an autism spectrum disorder or a related disability	June 22-24	Cerveney Conference Center Live Oak, Florida	May 11 <sup>th</sup>
Families who have a child with cerebral palsy	July 20-22	Cerveney Conference Center Live Oak, Florida	June 20 <sup>th</sup>
Families who have a child with cancer	August 24-26	FFA Leadership Training Center Haines City, Florida	July 24 <sup>th</sup>
Families who have a child with leukemia	September 14-16	The Fountains Orlando, Florida	August 14 <sup>th</sup>
Families who have a parent with breast cancer	October 12-14	FFA Leadership Training Center Haines City, Florida	September 12 <sup>th</sup>
Families who have a child with inflammatory bowel disease (IBD)	November 9-11	FFA Leadership Training Center Haines City, Florida	October 9 <sup>th</sup>

Once your application is completed, please email, mail or fax it by **May 11<sup>th</sup>** to:

**Marlena Jenkins**      6271 St. Augustine Rd, Ste 1 Jacksonville, Fl. 32217

**F: 904-633-0751    O: 904-633-0760    C: 904-651-5485    marlena.fuller@jax.ufl.edu**

# Frequently Asked Questions

## **When will I know if my family is selected to attend the retreat?**

You will be notified by Deliver the Dream of your families application status by the deadline date. Space is limited to 15 families so please make sure to turn your application in on time. Late applications will still be reviewed but will result in a lower priority status. A completed application does not guarantee acceptance.

## **What happens on a retreat?**

Deliver the Dream provides structured therapeutic family-centered activities for 15 families that offer respite, relaxation, and recreation for those who are experiencing similar challenges. A Deliver the Dream weekend will give you and your family a new sense of self and enhanced coping skills.

## **Are their age specific activities?**

Yes. Most of the activities include the entire family, but there are times when your family will be split up into groups based on age and illness or crisis. For the tots (ages 6-weeks to kindergarten), "Kids Korner" will be available during those time periods when parents are participating in structured activities. Youth (ages 6-12), teens (ages 13-18) and adults will participate in separate age appropriate selected activities too.

## **What types of activities will we be doing?**

You and your family will be participating in structured activities such as beading, tie dying, assorted recreational outdoor activities, discussion groups, interactive games, creative workshops, team building exercises, karaoke, Bingo, and more! If you have ever been to camp, we do a lot of the same activities. Ample time is also provided for relaxation, spending time with family members and meeting new supportive friends.

## **Where is the retreat located?**

Each retreat is offered at our selected venues which are miles away from the hustle and bustle of the crowded city. Each venue is unique but all are located in rustic surroundings where its natural beauty creates an atmosphere perfect for a fun-filled weekend retreat.

## **Where do we stay?**

Families will stay in hotel-like rooms with two double beds and a private bath (the number of rooms are based on the size of a family). Linens and towels are provided. Rooms are not equipped with a TV or telephone but there is wifi located in main buildings. Breakfast, lunch & dinner will be prepared by the food service professionals and is served buffet style in the main dining hall.

## **What does the retreat cost?**

Nothing! Thankfully, due to the generosity of our sponsors, Deliver the Dream will cover **ALL** lodging, activities, & group meal expenses. We will provide a \$50 gas card for your travel expenses when you arrive.

## **Can we get a letter for work or school explaining our absence?**

Yes. If your family is selected to go on the retreat Deliver the Dream can write a letter on your behalf.

## **What happens if someone from my family is not feeling well on the retreat?**

There is a medical professional on the retreat, who is available 24/7 to administer first aid for minor bumps and bruises. In the event of an emergency, they will assist in getting your family member to a local hospital.

## **Can we bring our pets?**

No. Pets are not allowed.

## **Can we bring alcohol?**

No. This is a drug and alcohol free weekend.



# Family Application

Please print clearly. Black/blue ink only.

What retreat are you applying for (*date only*): \_\_\_\_\_

Applicants Full Name: \_\_\_\_\_ M or F  
Parent or child with the serious illness or crisis

Relationship to the family: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

Estimated # of hospital visits per year: \_\_\_\_\_ Please tell us a little about the applicant: \_\_\_\_\_

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Please check any behavioral or emotional conditions that the applicant has/had been diagnosed with:  
ADD/ADHD   Anxiety   Depression   OCD   Other: \_\_\_\_\_  
\_\_\_\_\_

**Please list the other family members who will attend the retreat:**

_____	M or F	_____	_____	_____
First & Last Name		Relationship	DOB	Age
_____	M or F	_____	_____	_____
First & Last Name		Relationship	DOB	Age
_____	M or F	_____	_____	_____
First & Last Name		Relationship	DOB	Age
_____	M or F	_____	_____	_____
First & Last Name		Relationship	DOB	Age
_____	M or F	_____	_____	_____
First & Last Name		Relationship	DOB	Age
_____	M or F	_____	_____	_____
First & Last Name		Relationship	DOB	Age

Home Address \_\_\_\_\_ Apt/Suite \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Numbers \_\_\_\_\_  
Please include area codes                      cell                      home                      work

E-mail \_\_\_\_\_ Preferred method of communication: cell home work email mail  
You may circle more than one

**Other:**

List languages spoken by your family members (*please note that all sessions are in English*):

English   Spanish   French   Other \_\_\_\_\_

If a family member does not understand English please list their name(s) and language spoken:

\_\_\_\_\_

Please check all special equipment that your family will bring to the retreat:

Cane   Crib   Crutches   Electric Wheelchair   Non-Electric Wheelchair   Walker   Other   N/A

Please state who will be utilizing the items checked above: \_\_\_\_\_

Will that person need a handicapped accessible room?   Yes   No

Does your family require the use of a refrigerator for medications or baby formula?   Yes   No

*Please note: Parents must bring baby formula, diapers and baby food for all infants*

Has anyone in your family ever attended a sleep away or day camp?   Yes   No

Has your family ever received a wish or dream from another organization?   Yes   No   If yes, from what organization? \_\_\_\_\_

Who referred you to our program? \_\_\_\_\_

What organization/hospital are they from? \_\_\_\_\_

**Please write a brief paragraph to answer the following questions:**

Tell us about your family.

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How do you feel this retreat might be beneficial for all of you? \_\_\_\_\_

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# Applicant Medical History and Health Examination

The following information MUST be completed by the parent/guardian or adult applicant (*There is a section to be filled out by a physician medically clearing the applicant for the weekend*). This will provide the Deliver the Dream medical professional with appropriate information on the applicant's specific needs. If there are any changes to the health status of the applicant prior to the weekend, please notify Deliver the Dream.

( ) Female ( ) Male

\_\_\_\_\_ Last                      \_\_\_\_\_ First                      \_\_\_\_\_ Middle

\_\_\_\_\_ Date of Birth              \_\_\_\_\_ Age                      \_\_\_\_\_ Height                      \_\_\_\_\_ Weight

## Insurance Information

Name of Company: \_\_\_\_\_ Phone #: \_\_\_\_\_

Member ID: \_\_\_\_\_ Group #: \_\_\_\_\_

## Allergies

Does the participant have allergies to any food, medicines or any substance? ( ) Yes or ( ) No If yes, please list.

Allergies: \_\_\_\_\_ Reaction: \_\_\_\_\_

Allergies: \_\_\_\_\_ Reaction: \_\_\_\_\_

Allergies: \_\_\_\_\_ Reaction: \_\_\_\_\_

## Medications

Is the participant on any medications? ( ) Yes or ( ) No If yes, please list.

Medications	Reason	Amount	How Often

## Food Restrictions

Does the participant have any food restrictions? ( ) Yes or ( ) No If yes, please describe.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Provide additional information regarding the applicant's behavior. Describing their physical, emotional, or mental health which Deliver the Dream staff should be aware of.

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**Permission to Administer Treatment**

The information contained in this Health History Form is correct and complete to the best of my knowledge. I grant permission for the above-named guests herein to engage in Deliver the Dream Retreat Weekend activities with exception to those noted on this form and agree to abide by any restrictions placed on me or the child. I hereby give permission to Deliver the Dream on-site professional health staff to provide routine health care, administer prescribed medications (if necessary), and seek emergency medical treatment. I agree to the release of any records necessary for insurance purposes. I give permission to Deliver the Dream to arrange necessary health-related transportation for me/my minor child. In the event I cannot be reached during an emergency, I hereby give permission to the appropriate medical personnel selected by Deliver the Dream to secure and administer treatment, including hospitalization, for the above-named guests. If necessary, a copy of this completed form may be used for any trips away from the Deliver the Dream Retreat Weekend facility that may be offered as part of the overall program. This permission will also include scheduled transportation to and from the facility, ONLY if it is arranged and paid for by Deliver the Dream, Inc.

\_\_\_\_\_  
Parent/Legal Guardian Name

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

**Licensed Medical Professional's Health Care Recommendations**

**\*This portion is to be completed and signed by a licensed medical professional\***

I hereby attest that I am the treating physician for \_\_\_\_\_ and in my opinion, the named Guest (  ) IS or (  ) IS NOT able to participate in activities offered during the Deliver the Dream Retreat Weekend.

The applicant is under the care of a physician for the following condition(s):

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Medications and or treatment to be administered by parents/guardians during the Retreat Weekend:

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Any medically prescribed meal plan or dietary restrictions: \_\_\_\_\_

Description of any limitations or restrictions on weekend activities: \_\_\_\_\_

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Other: \_\_\_\_\_

\_\_\_\_\_  
Physician Printed Name

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Office Number

\_\_\_\_\_  
Pager (in case of emergency)



# Family Medical and Emergency Information

**Please do not add the applicant to this form.** This form is for the other family members attending the retreat. All of this information is keep confidential and will only be shared with Deliver the Dream's medical professional. It is extremely important that you fill this form out in its entirety. Please print clearly and list each family member individually.

**1. First and Last Name:** \_\_\_\_\_

Does the participant have allergies to any food, medicines or any substance? YES or NO If yes, please list.

Allergies: \_\_\_\_\_ Reaction: \_\_\_\_\_

Allergies: \_\_\_\_\_ Reaction: \_\_\_\_\_

Allergies: \_\_\_\_\_ Reaction: \_\_\_\_\_

Does the participant have any food restrictions?(vegetarian, no meat, gluten free, etc.) YES or NO If yes, please list.

Does the participant have any health conditions that may limit their participation? YES or NO If yes, please explain.

Please list all current over the counter or prescription medications. \_\_\_\_\_ Check here for no medications

Medications	Amount	How Often

**2. First and Last Name:** \_\_\_\_\_

Does the participant have allergies to any food, medicines or any substance? YES or NO If yes, please list.

Allergies: \_\_\_\_\_ Reaction: \_\_\_\_\_

Allergies: \_\_\_\_\_ Reaction: \_\_\_\_\_

Allergies: \_\_\_\_\_ Reaction: \_\_\_\_\_

Does the participant have any food restrictions?(vegetarian, no meat, gluten free, etc.) YES or NO If yes, please list.

Does the participant have any health conditions that may limit their participation? YES or NO If yes, please explain.

Please list all current over the counter or prescription medications. \_\_\_\_\_ Check here for no medications

Medications	Amount	How Often

**3. First and Last Name:** \_\_\_\_\_

Does the participant have allergies to any food, medicines or any substance? YES or NO If yes, please list.

Allergies: \_\_\_\_\_ Reaction: \_\_\_\_\_

Allergies: \_\_\_\_\_ Reaction: \_\_\_\_\_

Allergies: \_\_\_\_\_ Reaction: \_\_\_\_\_

Does the participant have any food restrictions?(vegetarian, no meat, gluten free, etc.) YES or NO If yes, please list.

Does the participant have any health conditions that may limit their participation? YES or NO If yes, please explain.

Please list all current over the counter or prescription medications. \_\_\_\_\_ Check here for no medications

Medications	Amount	How Often

**4. First and Last Name:** \_\_\_\_\_

Does the participant have allergies to any food, medicines or any substance? YES or NO If yes, please list.

Allergies: \_\_\_\_\_ Reaction: \_\_\_\_\_

Allergies: \_\_\_\_\_ Reaction: \_\_\_\_\_

Allergies: \_\_\_\_\_ Reaction: \_\_\_\_\_

Does the participant have any food restrictions?(vegetarian, no meat, gluten free, etc.) YES or NO If yes, please list.

Does the participant have any health conditions that may limit their participation? YES or NO If yes, please explain.

Please list all current over the counter or prescription medications. \_\_\_\_\_ Check here for no medications

Medications	Amount	How Often

5. First and Last Name: \_\_\_\_\_

Does the participant have allergies to any food, medicines or any substance? YES or NO If yes, please list.

Allergies: \_\_\_\_\_ Reaction: \_\_\_\_\_

Allergies: \_\_\_\_\_ Reaction: \_\_\_\_\_

Does the participant have any food restrictions?(vegetarian, no meat, gluten free, etc.) YES or NO If yes, please list.

Does the participant have any health conditions that may limit their participation? YES or NO If yes, please explain.

Please list all current over the counter or prescription medications. \_\_\_\_\_ Check here for no medications

Medications	Amount	How Often

6. First and Last Name: \_\_\_\_\_

Does the participant have allergies to any food, medicines or any substance? YES or NO If yes, please list.

Allergies: \_\_\_\_\_ Reaction: \_\_\_\_\_

Allergies: \_\_\_\_\_ Reaction: \_\_\_\_\_

Does the participant have any food restrictions?(vegetarian, no meat, gluten free, etc.) YES or NO If yes, please list.

Does the participant have any health conditions that may limit their participation? YES or NO If yes, please explain.

Please list all current over the counter or prescription medications. \_\_\_\_\_ Check here for no medications

Medications	Amount	How Often

**Emergency Contact:**

_____	_____	_____
Name	Relationship	Phone Number

**Permission to Administer Treatment**

The information contained in this Family Medical and Emergency Information Form is correct and complete to the best of my knowledge. I grant permission for the above-named guests herein to engage in Deliver the Dream Retreat Weekend activities with exception to those noted on this form and agree to abide by any restrictions placed on me or the child. I hereby give permission to Deliver the Dream on-site professional health staff to provide routine health care, administer prescribed medications (if necessary), and seek emergency medical treatment. I agree to the release of any records necessary for insurance purposes. I give permission to Deliver the Dream to arrange necessary health-related transportation for me/my minor child. In the event I cannot be reached during an emergency, I hereby give permission to the appropriate medical personnel selected by Deliver the Dream to secure and administer treatment, including hospitalization, for the above-named guests. If necessary, a copy of this completed form may be used for any trips away from the Deliver the Dream Retreat Weekend facility that may be offered as part of the overall program. This permission will also include scheduled transportation to and from the facility, ONLY if it is arranged and paid for by Deliver the Dream, Inc.

_____	_____	_____
Parent/Legal Guardian Name	Parent/Legal Guardian Signature	Date

# Releases for Publication, Travel, Participation and Claims

Please list every family member attending the retreat below. First and last names please.

- |          |          |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

## Release for Publication (please initial yes or no below)

During the course of the Deliver the Dream experience, there will be occasions when your family members may be photographed and/or videotaped by staff, sponsors, corporate representatives, media and others. We request permission for you and your family member's participation. By initialing below, parents and/or guardians may choose to grant or deny Deliver the Dream, Inc. permission to use photographs or videotapes of the above-named family members, alone or in groups, in newspaper articles, newsletters, Web-site, brochures, special fundraising activities, scrapbook, videos and photo albums for use in public understanding and support of the Deliver the Dream program. By granting permission below, you hereby release and hold harmless Deliver the Dream, Inc. from any claims, judgments or demands which may arise from the use of the above referenced photographs and/or videotapes.

_____	"YES, I/we give permission for the above-named	<b>OR</b>	_____	"NO, I/we deny consent for the above-named
Initial	guests to be photographed and/or		Initial	guests to be photographed and/or
	videotaped for publication".			videotaped for publication".

## Permission to Participate, Travel and Release of Claims (please fill out below)

I/We, on behalf of myself or ourselves, and as parent(s)/guardian(s) of the \_\_\_\_\_ **family** minor children, hereby give permission for the above-named family members (hereinafter "the Family") to travel to \_\_\_\_\_ **(retreat location)** on \_\_\_\_\_ **(date)**, as participants in the Deliver the Dream Retreat Weekend Program (hereinafter "the Retreat Weekend"). I/We understand that "the Family" will travel by car to "the Retreat Weekend" which will take place from \_\_\_\_\_ **(date)**. I/We understand that while at "the Weekend", depending on the venue, "the Family" may be offered \*physical activities including, but not limited to rock wall climbing, swimming, boating, arts & crafts, archery, tennis and basketball. (\*Please note activities are subject to change depending upon the venue).

In consideration of participation in "the Retreat Weekend", I/we, for myself/ourselves, heirs, executors, and administrators, hereby personally and on behalf of "the Family", release, indemnify, save and hold harmless, acquit, forever discharge and waive any claims or causes of action which "the Family" or I/we may now or hereafter have against Deliver the Dream, Inc. other participating agencies, all corporate sponsors and collaborators, and their respective subsidiaries and affiliates and any and all of their officers, directors, trustees, agents, servants, associates, employees, representatives, shareholders, beneficiaries, successors, and assigns, of all liabilities, claims, actions, damages, costs, or expenses which they or I/we may now or hereafter have arising out of or in any way connected with participation by "the Family" in Deliver the Dream, including, but not limited to, travel to or from "the Retreat Weekend" and injuries which may be suffered before, during, or after "the Retreat Weekend". I/we understand that this waiver includes any claims based on negligence, action, or inaction of the above parties. I/we understand that we are assuming the risk for any activities we participate.

_____	_____	_____
Parent/Legal Guardian Name	Parent/Legal Guardian Signature	Date