Post Polio Wellness Retreat for Polio Survivors
Bay Cliff Health Camp
October 15 - 18, 2019

APPLICATION

Name: ____ Date of Birth: _________________

Address: ____

City: ___________________________ State: _______________ Zip Code: _____________

Phone Number: __________________________ Email: ______________________________

Date in Year(s) that you had Polio: ____

Where was home at the time? ____

Have you ever been to Bay Cliff? ____

How did you hear about the Post Polio Wellness Retreat? ______________________________

____

Have you been diagnosed with Post Polio Syndrome? _________________________________

If so, how does Post Polio affect you? ____

____

Current Functional Level: (check all that apply)

Breathing: _____ Independent ______ With Oxygen Tank ______ With Ventilator

_____ Use an inhaler ______ Use CPAP at night

Mobility: _____ Independent ______ With Assistance from a Person

_____ Walker ______ Crutches ______ Cane ______ Orthotic/Brace

_____ Manual Wheelchair ______ Power Wheelchair ______ Scooter

Would you need assistance to walk or wheel 100 yards, which includes a small incline?

YES NO

Are you able to climb a flight of stairs?
______ Yes, without difficulty.
______ Yes, but I need to take my time.
______ I am unable to climb a flight of stairs

Dressing: _____ Independent ______ With Assist

Feeding: _____ Independent ______ With Assist

Bathing Equipment (if applicable):

_____ I will bring my own shower bench.
_____ I would like to borrow a bench. (Describe type used:______________________________)

CAREGIVER/SPOUSE INFORMATION

A limited number of spaces are available for caregivers/spouses of polio survivors to also attend the retreat. Caregivers/spouses will attend all educational sessions and activities with the polio survivor they are assisting. There will also be some sessions available just for caregivers/spouses to provide them with education, training, and support. Caregivers/spouses will pay the same fee as participants.

Do you have a caregiver? (circle one) YES NO

_____ I am independent with my daily cares but my spouse would still like to attend to learn about Post Polio Syndrome.

If "yes" to either question above, please provide the following information:

Caregiver/Spouse's Name: ____

Address: ____

City: _______________________________ State: ______________ Zip Code: ____________

Phone Number: ___________________________ Email: _______________________________

Allergies/Special Diet Needs of Caregiver: ____

My Caregiver assists me with: ____

____

My Caregiver is interested in learning: ____

____

____

PHYSICIAN INFORMATION

Physician's Name: ____________________________________ Phone: ______________________

Address: ____

City: ______________________________ State: _______________ Zip Code: ________________

Date of Last Visit: ____

HEALTH HISTORY

______ Asthma   Other:_______________________________________

______ Diabetes   _______________________________________

______ Heart Disease   _______________________________________

______ Hypertension/High Blood Pressure   _______________________________________

PRECAUTIONS

____

____

MEDICATIONS

List all medications that you are currently taking. Please bring all medications with you in their original prescription containers.

Medication	Dose	Times Taken	Taken for…

ALLERGIES

Please include medications, foods, insect bites, bee stings, etc.

____

SPECIAL DIETARY NEEDS

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____

Please provide additional information about health or medical concerns that we should know about:

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EDUCATIONAL SESSIONS

Each morning, all participants will attend an educational session on Wellness as it relates to Polio Survivors and Post Polio Syndrome.

EXERCISE OPTIONS

Exercise is an important component to Post-Polio Wellness. Exercise classes will follow the educational session each day. Which of the following exercise sessions are you interested in?

______ Aquatics

______ Cardio

______ Exercises for Balance

______ Seated Exercises for Stretching & Strengthening

______ Shoulders – Care & Strengthening

______ Tai Chi

______ Yoga

RECREATIONAL OPTIONS
Every afternoon there will be time set aside for recreation. Please Note: All activities will be adaptable to all ability levels! This is an opportunity to try something new!

Which of the following would you like to experience at Bay Cliff?
(Please check all that apply and then number your top four choices.)

______ Adaptive Biking & Handcycling

______ Adaptive Kayaking

______ Arts & Crafts

______ Berry Jam Making

______ Birding

______ Ceramics

______ Fishing

______ Information & Tips for Handicap Travel

______ Jewelry Making

______ Journaling

______ Lighthouse Tour

______ Make Your Own Walking Stick

______ Nature Hike (accessible)

______ Outdoor Cooking

______ Pottery

______ Sauna Time

______ Swimming in the Lake

______ Swimming in the Pool

______ Watercolors

______ Woodworking

______ Other Interests/Requests:

AFTERNOON BREAKOUT SESSIONS

The breakout sessions are intended to share information and ask questions in a small group setting. They will take place on Tuesday, Wednesday, Thursday & Friday. We are in the process of scheduling certain sessions on certain days. When you arrive at Bay Cliff, you will be provided with the schedule for the week. This form that you are filling out now will give health care professionals an idea of your interests for planning purposes. Most "Ask the Doctor" sessions will be with Dr. Maynard. Dr. Maynard will also be available throughout the retreat to answer any questions you may have.

Which of the following are you interested in attending?

Very Interested	Interested	Not Interested	
________	________	_______	Ask the Doctor: Aging & General Health
________	________	_______	Ask the Doctor: Fatigue Management
________	________	_______	Ask the Doctor: Pain Management
________	________	_______	Ask the Doctor, Orthotist & Therapist: Bracing & Walking Aids
________	________	_______	Ask the Neuropsychologist: Cognitive & Emotional Issues/Coping
________	________	_______	Ask the Occupational Therapist: Equipment & Techniques for Daily Living
________	________	_______	Ask the Nurse: How to Best Access & Use Complimentary Medicine
________	________	_______	Ask the Physical Therapist: Fall Prevention
________	________	_______	Ask the Psychologist: Pain Management
________	________	_______	Ask the Speech Therapist: Swallowing Issues
________	________	_______	Action Plan for Healthy Living
________	________	_______	Bowel & Bladder Issues
________	________	_______	Breathing
________	________	_______	Good Planning As We Age (Advance Directives, Durable Power of Attorney, Housing Options, etc.)
________	________	_______	Integrating Spirituality
________	________	_______	Michigan Polio Network & Other Resources for Polio Survivors
________	________	_______	Safety & Self Defense
________	________	_______	Sleep Issues
________	________	_______	Stress Management & Relaxation Strategies
________	________	_______	Weight Loss Strategies
________	________	_______	Wheeled Mobility

Other Requests for Breakout Sessions: ____

YOUR GOALS

To assist us in finalizing the program for the retreat, please share one or two personal goals that you have in the area of personal health & wellness.

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CAREGIVER/SPOUSE GOALS

We will be putting together some educational/support sessions for caregivers/spouses that attend the retreat. If you are bringing a caregiver/spouse along with you, what are their goals related to Post Polio Syndrome?

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Since space is limited, please return this form as soon as possible to:

Bay Cliff Health Camp
PO Box 310
Big Bay, MI 49808
(906)345-9314

If you have any questions, please call Bay Cliff and ask for
Martha Process, Children's Services/Program Director
or email us at baycliff@baycliff.org.

You will be notified by October 1 about the status of your application.