

# Holiday Application Form



www.break-charity.org

To help us fully meet the needs of our guests, please complete all relevant sections using block capital letters and ticking the appropriate boxes.

If you have any questions about how to fill in this form phone our Head Office on 01263 822161.

Please enclose a photograph of guest.

If you are completing this form on behalf of a guest please print your name and a contact telephone number in the space provided:

Name: \_\_\_\_\_ Tel: \_\_\_\_\_

**Return completed form to:**

Guest Bookings Administrator, Break, Davison House, 1 Montague Road, Sheringham, Norfolk NR26 8WN

## 1 GUEST'S PERSONAL DETAILS

Surname \_\_\_\_\_ First name(s) \_\_\_\_\_

Name by which the guest prefers to be known \_\_\_\_\_

Home address \_\_\_\_\_

\_\_\_\_\_ Postcode \_\_\_\_\_

To help meet the guest's needs, please give details of ethnic, cultural and linguistic background and religious beliefs.

Ethnic Origin \_\_\_\_\_

Religion \_\_\_\_\_

Telephone Number \_\_\_\_\_

NHS Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Weight \_\_\_\_\_ Height \_\_\_\_\_

Email address \_\_\_\_\_

## 2 PLACEMENT PLAN (Preferred date of holiday with preference at No.1)

Dates

1. \_\_\_\_\_ to \_\_\_\_\_

2. \_\_\_\_\_ to \_\_\_\_\_

3. \_\_\_\_\_ to \_\_\_\_\_

4. \_\_\_\_\_ to \_\_\_\_\_

5. \_\_\_\_\_ to \_\_\_\_\_

6. \_\_\_\_\_ to \_\_\_\_\_

Has guest stayed away from home before?  Yes  No

### 3 CARE STANDARDS ACT 2000

Give details of any Court Order or contact restrictions in force:

### 4 CONTACTS

**Next of kin/person with parental responsibility** – Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Postcode \_\_\_\_\_

Telephone Number \_\_\_\_\_ Relationship to guest \_\_\_\_\_

**Doctor** – Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Postcode \_\_\_\_\_

**Social Worker/Community LD Nurse** – Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Postcode \_\_\_\_\_

**School** – Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

School Address \_\_\_\_\_

**Emergency contact** – Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

Address \_\_\_\_\_

Relationship to applicant \_\_\_\_\_

### 5 NATURE OF DISABILITY

Learning Disability

Physical Disability

Both

Specific diagnosis and degree of disability:

### 6 MEDICATION

**Please Note: If guests require medication a supply sufficient to last the duration of the stay must be provided. It would be particularly helpful if this could be in a blister pack. Your chemist should be able to help you with this. If blister packs are not available, please note that we can only accept medication in its original container and the dosage instructions must be clearly written on the label. PLEASE SEND A LIST OF CURRENT MEDICATION WITH YOUR CONFIRMATION**

## 7 MEDICAL DETAILS

Tetanus – Date of last vaccination \_\_\_\_\_

**Does the guest have or require treatment for any of the following conditions?**

|  |  |   |
|--|--|---|
| Asthma attacks   | <input type="checkbox"/> Yes <input type="checkbox"/> No | How often?                                    |
| Describe what happens  |  |   |
| Action required  |  |   |
| Chest infection  | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |
| Action required  |  |   |
| Allergies  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cause(s) of allergy                           |
| Symptoms   |  |   |
| Action required  |  |   |
| Diabetes   | <input type="checkbox"/> Yes <input type="checkbox"/> No | If 'yes', please enclose Individual Care Plan |
| Symptoms of Hypo   |  |   |
| Action required  |  |   |
| Symptoms of Hyper  |  |   |
| Action required  |  |   |
| Heart condition  | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |
| Give details of any special consideration or action required |  |   |
| Travel sickness  | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |
| Action required  |  |   |
| Urinary infection  | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |
| Action required  |  |   |
| Significant viral infection                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |
| Action required  |  |   |

## 7 MEDICAL DETAILS – continued...

Epilepsy  Yes  No

If PRN is required, i.e. Diazepam/Buccal Molazolam, please enclose Individual Care Plan to enable trained staff to administer if required.

If yes, what type of Epilepsy does the guest have \_\_\_\_\_

MAJOR SEIZURES (convulsive)  Yes  No (delete as appropriate)

MINOR SEIZURES  Yes  No

OTHERS (please specify) \_\_\_\_\_

How often do these seizures occur? \_\_\_\_\_

Does the guest take medication for epilepsy?  Yes  No

**If YES, please ensure that you complete the details of these on the section below.**

**If PRN is required, i.e. Diazepam/Buccal Molazolam, please also complete the enclosed form and accompany this with the Individual Care Plan to enable trained staff to administer if required.**

Does the guest know when they are going to have a seizure?  Yes  No

Please describe typical seizures \_\_\_\_\_

How long do they last? \_\_\_\_\_

Do we need to know of any emergency procedure?  Yes  No

Please give details of emergency treatment and when it should be put into operation \_\_\_\_\_

Other – give details

Details of medication being taken

Request for protocols from Doctor for Midazalan and Retal Diazepan

Action required

## 8 MORNING/WAKING ROUTINE

|   |  |               |
|---|--|---------------|
| Preferred time of waking  | Weekday _____  | Weekend _____ |
| Alarm call needed?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |               |
| Can guest wash self?<br><input type="checkbox"/> Yes <input type="checkbox"/> No        | Special instructions                                     |               |
| Can guest bath/shower self?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | Help required?   |               |
| Can guest dress self?<br><input type="checkbox"/> Yes <input type="checkbox"/> No       | Help required?   |               |
| Does guest like to remain in their own room?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |               |
| Does guest prefer to go to Sitting Room/Lounge?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |               |

## 9 BEDTIME/SLEEPING ROUTINE

|  |  |   |                                    |
|--|--|---|------------------------------------|
| Does guest sleep in? (Tick one)  | Bed <input type="checkbox"/>                             | Bed with cot sides <input type="checkbox"/> | Cot <input type="checkbox"/>       |
| Other <input type="checkbox"/> (give details) _____  |  |   |                                    |
| Number of pillows?   |  |   |                                    |
| <b>Other information</b>   | Give details   |   |                                    |
| Does guest enjoy a bath in the evening?<br><input type="checkbox"/> Yes <input type="checkbox"/> No        |  |   |                                    |
| Does guest sleep well?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                         |  |   |                                    |
| Does guest need medication to assist sleeping?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |   |                                    |
| Does guest sleep with night-light?<br><input type="checkbox"/> Yes <input type="checkbox"/> No             |  |   |                                    |
| Preferred time of retiring?  |  |   |                                    |
| Preferred bedtime drinks   |  |   |                                    |
| Horlicks <input type="checkbox"/>  | Hot milk <input type="checkbox"/>                        | Tea/Coffee <input type="checkbox"/>         | Chocolate <input type="checkbox"/> |
|  |  |   | Ovaltine <input type="checkbox"/>  |
| Do they take this in their bedroom?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |                                    |

## 10 MEAL TIMES

Does guest use? Knife  Fork  Spoon  Cup  Feeder  Special Implements

How is food taken? Liquidised  Cut up  Minced

Normally  Tube Feeding  (give details) \_\_\_\_\_

|   |              |
|---|--------------|
| Does guest need assistance with eating?<br><input type="checkbox"/> Yes <input type="checkbox"/> No       | Give details |
| Does guest need assistance with cutting food?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | Give details |
| Appetite? Small <input type="checkbox"/> Good <input type="checkbox"/>                                    | Comments     |
| <b>Other Information</b>  | Give details |
| Known food dislikes   |              |
| Favourite foods   |              |
| Special dietary needs   |              |

## 11 TOILET ROUTINE

|  |  |
|--|--|
| <b>Is guest incontinent?</b>   | Give details   |
| Bowels<br>Day: <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Night: <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| What do normal stools look like?   |  |
| Urine<br>Day: <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Night: <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| Can guest use toilet independently?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| Does guest use pads?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | <b>NB. If guest is incontinent please allow an adequate supply of incontinence pads for their stay</b> |
| Does the guest need regular toileting?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| Is Stoma care needed?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| Is guest catheterised?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |

## 12 COMPREHENSION AND COMMUNICATION SKILLS

| How does the guest tell you when they are... | What does the guest say?<br>What noises do they make or what signs do they use? | What does the guest do with their hands, feet, body language and so on? |
|--|---|---|
| Bored?                                       |   |   |
| Tired?                                       |   |   |
| Hungry?                                      |   |   |
| Thirsty?                                     |   |   |
| Feeling angry?                               |   |   |
| Feeling sad?                                 |   |   |
| Feeling happy?                               |   |   |
| Are in pain?                                 |   |   |
| Want to go to the toilet?                    |   |   |
| Want to go out?                              |   |   |
| Want to be alone?                            |   |   |
| Need help?                                   |   |   |
| Like someone?                                |   |   |
| Dislikes someone?                            |   |   |

Other things you have noticed the guest communicating; how do they do this?

Does the guest have a favourite toy or comforter?  Yes  No

Please give details and arrange to be included on stay.

## 13 ABILITIES

| Can guest  | Comments              |
|--|-----------------------|
| See<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |                       |
| Hear<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |                       |
| Walk<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | State distance:       |
| Sit unsupported<br><input type="checkbox"/> Yes <input type="checkbox"/> No                              |                       |
| Climb stairs<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                 | How is this achieved? |
| Weight/bear transfer self<br>from wheelchair<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                       |

## 14 BEHAVIOUR

| Behaviour pattern  | What happens, when and how often? | How is this managed? |
|--|-----------------------------------|----------------------|
| Aggression<br><input type="checkbox"/> Yes <input type="checkbox"/> No       |                                   |                      |
| Destructiveness<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |                                   |                      |
| Hyperactivity<br><input type="checkbox"/> Yes <input type="checkbox"/> No    |                                   |                      |
| Temper tantrums<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |                                   |                      |
| Over excitable<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |                                   |                      |
| Over emotional<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |                                   |                      |
| Easily upset<br><input type="checkbox"/> Yes <input type="checkbox"/> No     |                                   |                      |
| Other behaviours<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                   |                      |

## 14 BEHAVIOUR – continued...

| Behaviour pattern   | What happens, when and how often? | How is this managed? |
|---|-----------------------------------|----------------------|
| Noisy<br><input type="checkbox"/> Yes <input type="checkbox"/> No                   |                                   |                      |
| Self harm<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |                                   |                      |
| Any other sensitivities<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                   |                      |
| Plays with water?<br><input type="checkbox"/> Yes <input type="checkbox"/> No       |                                   |                      |

## 15 ASSESSING RISK

To help us ensure the safety of all guests, please list any concerns you may have regarding the following –

| Risk                                | Comments |
|-------------------------------------|----------|
| Self harm                           |          |
| Being bullied                       |          |
| Physical injury from others         |          |
| Transport issues                    |          |
| Self injury from reckless behaviour |          |
| Aggressive/challenging behaviour    |          |
| Sense of danger                     |          |

## 15 ASSESSING RISK – continued...

| Risk                                       | Comments     |
|--|--------------|
| Absconding/getting lost/<br>wandering      |              |
| Mobility / falling / slipping etc.         |              |
| Moving and handling issues                 |              |
| Emotional upset                            |              |
| Sexual issues                              |              |
| Hoarding/ownership of<br>property problems |              |
| Night attention                            |              |
| Eating problems                            |              |
| Fire/burns                                 |              |
| Please list any other<br>risks/concerns    | Give details |

## 16 TRANSPORTATION

| Preferred method of transport    | Yes | No | Additional information to assist with transportation |
|----------------------------------|-----|----|--|
| Transfer from wheelchair to seat |     |    |  |
| Remains in wheelchair            |     |    |  |
| Uses booster seat                |     |    |  |
| Uses child car seat              |     |    |  |
| Other transport issues           |     |    |  |

## 17 MOVING AND HANDLING CONSTRAINTS

|                                  | Action Required? |    | Details of aid/assistance required |
|----------------------------------|------------------|----|------------------------------------|
|                                  | Yes              | No |                                    |
| Uncontrolled Spasms              |                  |    |                                    |
| Head Control                     |                  |    |                                    |
| Fragile Bones                    |                  |    |                                    |
| Epilepsy                         |                  |    |                                    |
| Unreliable Behaviour             |                  |    |                                    |
| Flaccid Limbs                    |                  |    |                                    |
| Lower Limb Function              |                  |    |                                    |
| Upper Limb Function              |                  |    |                                    |
| Impaired Balance                 |                  |    |                                    |
| Spinal Fusion                    |                  |    |                                    |
| General Fragility/Skin Condition |                  |    |                                    |
| Body Brace                       |                  |    |                                    |
| Stoma Site                       |                  |    |                                    |
| Gastro Feed Site                 |                  |    |                                    |
| Catheter                         |                  |    |                                    |

## 18 SUPPORT EQUIPMENT – any aids used must be supplied by guest

| Please indicate what assistant the guest requires | Yes | No |
|---|-----|----|
| Independent                                       |     |    |
| Supervised/prompted                               |     |    |
| Assisted  |     |    |
| Dependent   |     |    |
| Hoisted   |     |    |

### Wheelchair use

|   |   |   |
|---|---|---|
| Does guest use a wheelchair?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><br>Dimensions:<br>Size: _____<br><br>_____ | If 'yes', is wheelchair:<br><br>Pushed <input type="checkbox"/> Yes <input type="checkbox"/> No<br><br>Self-propelled <input type="checkbox"/> Yes <input type="checkbox"/> No<br><br>For distances only <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>If wheelchair user, guest <u>must</u> use footplates and wear seat belt to comply with Health and Safety regulations</b> |
|---|---|---|

**Other aids** - any aids, other than hoisting equipment (see below), must be supplied by the guest.

| Does guest use  | Yes | No | Details / additional information regarding aids used  |
|---|-----|----|---|
| A.F.O.  |     |    |   |
| Handling Belt   |     |    |   |
| Transfer board  |     |    |   |
| Rolator/Turntable   |     |    |   |
| Hoists  |     |    | <b>If yes, please detail, make, style and size of sling, and loop positioning for hoisting.</b> |
| <i>Our holiday centre has mobile hoists and a limited number of variable styles/sizes of slings are available.<br/>                     To check compatibility prior to your stay, please include <b>make</b> and <b>style</b> of hoist and sling regularly used by yourself, and also <b>loop positioning</b> used when hoisting.<br/>                     N.B. In some cases it may be necessary to ask for the hoist/sling to be supplied.</i> |     |    |   |
| Spectacles  |     |    |   |
| Sticks/Calipers   |     |    |   |
| Special shoes   |     |    |   |
| Hearing aids  |     |    |   |

## 19 LEISURE AND OTHER INTERESTS – to help staff with guests wishing more independence

Give details of any interests or care programmes (please tick boxes)

Computers   
  TV   
  Radio   
  Music   
  Regular outings   
  Outings to places of interest

Will they bring in some of their own toys and leisure equipment?

Yes     No

Give details

Is the guest able to go on unaccompanied outings?

Yes     No

Give details

Can the guest have alcohol (according to medical restrictions)?  Yes     No

Is there a limit/restriction?

Yes     No

Give details

Does the guest smoke?     Yes     No

Is there a limit/restriction?

Yes     No

Give details

## 20 SWIMMING

There is the opportunity of swimming sessions at the on-site indoor pool. All sessions are supervised by Poolside Rescuer staff and other staff join guests in the pool.

Would you like the guest to go swimming if it can be arranged?  Yes     No

If yes – please indicate guest's swimming ability (tick one)

Strong   
  Capable   
  Weak   
  Non-swimmer

Swimming aids used \_\_\_\_\_

Is there any special care/attention required prior to entering the pool? \_\_\_\_\_

If the guest has **epilepsy**, please advise what signs or symptoms should the swimming supervisor look for prior to a seizure?

\_\_\_\_\_

Signed \_\_\_\_\_ Relationship to guest \_\_\_\_\_

Pool Risk Assessment - RAINBOW

Name of Assessor \_\_\_\_\_ Position \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

## 21 FAMILY COMPOSITION

Please give brief report here or attach separate sheets

## 22 TERMS OF SHORT BREAKS

1. **Length of stay** – Short breaks are agreed according to guests' care plan.
2. **Staff** – Rainbow is staffed 24 hours daily. Waking night staff support guests during the night. Supervision of guests is provided at all times. Guests who are able to exercise a high degree of independence can be given the freedom to do so provided this is agreed in advance in writing.
3. **Accommodation** – Rainbow is a two story building with lounge, play area, dining room and bathing/toilet facilities, all with central heating and a lift. There are bath hoists, showers and toilet supports. Outside there is an enclosed play area and garden.
4. **Bedrooms** – Rainbow has ten single bedrooms.
5. **Meals** – Breakfast, dinner and tea are provided each day with a drink and a light snack for supper. Special diets can be provided.
6. **Programme** – A comprehensive programme is provided which includes some of the following activities: On Site: Disco, Barbecue, TV/Videos, Games, Parties (every guest celebrating a birthday has a party and birthday cake). Off Site: Local community facilities can be accessed as part of a leisure programme according to guests wishes and availability. No charge is made to guests for transport for the leisure programme.
7. **Clothing** – It is essential that clothing is named. Every attempt is made to safeguard guests' clothing but no responsibility can be accepted for lost articles.

## 22 TERMS OF SHORT BREAKS – continued...

8. **Laundry** – Rainbow has on-site laundry facilities. Only clothing which is named for easy identification will be laundered.
9. **Valuables** – Rainbow does not have means of securing guests' valuables, therefore, any such items are brought at guests' own risk.
10. **Medical treatment** – Staff do not have medical qualifications. They take care of and administer guests' medication and maintain a daily record. Break does not hold guests' medical records and cannot accept responsibility for the medication and instructions supplied. Arrangements are made with the local health centre to cover any special requirements, e.g. injections.  
**NO MEDICATION WILL BE ADMINISTERED WITHOUT A CORRECT READABLE UNALTERED PHARMACY LABEL**
11. **Pocket money** – Pocket money is required to enable additional outings. This is administered by staff and a full record of transactions is kept. A copy of this record is sent home with guests.
12. **Insurance** – Guests are insured by Break to cover all circumstances where Break is legally responsible for their safety.
13. **Environment** – Every endeavor is made to respect guests' right of privacy, dignity, choice, independence and fulfillment.
14. **Pets** – We regret that no pets (except guide dogs) can be accepted.
15. **Termination** – Once in residence a placement may be cancelled due to acute illness, contagious disease or distress to themselves or other residents. Termination of placement under the advisement of the Area Child Protection Procedures/Adult Protection Procedures. Where the behavior of a guest is likely to place fellow guests at risk, the placement may be terminated early. If a guests' placement has to be terminated early, for whatever reason, it is the responsibility of the parent/carer or placing authority to arrange removal.
16. **Guests** – Arrival and departure times by prior arrangement.

## 23 REPORTS ENCLOSED

- |  |                              |                             |                   |                              |                             |
|--|------------------------------|-----------------------------|-------------------|------------------------------|-----------------------------|
| Psychological  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Social Work/other | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Medical/psychiatric  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Education         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Copy of current Individual Care Plan/s                               | <input type="checkbox"/> Yes |                             | Core assessment   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Protocol Form for the administration of Rectal Diazepam or Midazolam |                              |                             |                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Protocol Form for the administration of Insulin                      |                              |                             |                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
- I have taken a copy of this completed form for my records  Yes  No

## 24 DATA PROTECTION

I understand and agree that Break is permitted to hold personal information about the guest as identified in this Application Form as part of its guests' records and may use such information in the course of the guests care.

The guest agrees that by completing this Application Form Break may disclose such information to third parties in the event that such disclosure is, in the organisation's view, required for the proper conduct of the guests care. This applies to the information held, used and disclosed in any medium.

## 25 PERSON OR AUTHORITY RESPONSIBLE FOR BOOKING

Please read the Terms of Short Breaks and Data Protection notice before signing this form.

Name: \_\_\_\_\_ Relationship to guest: \_\_\_\_\_

Address: \_\_\_\_\_

Postcode: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

### Invoice details - Person/Authority responsible for payment

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Postcode: \_\_\_\_\_

Signed: \_\_\_\_\_ Print: \_\_\_\_\_

## 26 HOW DID YOU HEAR ABOUT BREAK

Please help us to monitor how information about our services has reached you. You may tick more than one box if applicable.

- |  |                          |                           |                          |
|--|--------------------------|---------------------------|--------------------------|
| Referral (Social Services/Healthcare Professional)     | <input type="checkbox"/> | Friend/Family/Carer       | <input type="checkbox"/> |
| Support/Social Group                                   | <input type="checkbox"/> | Break Charity shop        | <input type="checkbox"/> |
| Community Information (Library/Citizens Advice Bureau) | <input type="checkbox"/> | Break information leaflet | <input type="checkbox"/> |
| Media (Newspaper/Magazine/Radio/TV)                    | <input type="checkbox"/> | Break website/internet    | <input type="checkbox"/> |
| Presentation/Talk/Exhibition                           | <input type="checkbox"/> | Break fundraising event   | <input type="checkbox"/> |

Other (please specify): \_\_\_\_\_

### For office use only