REGISTRATION FORM – Real Voices Real Choices Conference 2017

DETAILS

Conference Logistics: The Real Voices Real Choices Conference will be held on August 20 – 22, 2017 at Tan-Tar-A Resort and Conference Center.

Please choose one of the following:

☐**$95.00**	☐**$160.00*** **	☐**$160.00**
Single Registration – Consumer, Self-Advocate, Person in Recovery, or Family Member. This cost includes your hotel room for Sunday and Monday evening, all conference materials, all conference activities and 4 planned meals including dinner on Sunday evening, breakfast and lunch on Monday and breakfast on Tuesday.	**Double Registration** - Consumer, Self-Advocate, Person in Recovery, or Family Member. This cost includes **ONE SLEEPING ROOM TO SHARE** for two nights, all conference materials, activities and 4 planned meals including dinner on Sunday evening, breakfast and lunch on Monday and breakfast on Tuesday for TWO PEOPLE. *****Second registrant will need to complete a separate form and send in.** **Name of Roommate:**	**Professional Registration** - This cost includes all conference materials, all conference activities and 4 planned meals including dinner on Sunday evening, breakfast and lunch on Monday and breakfast on Tuesday. You are responsible for making your lodging arrangements with Tan-Tar-A Resort. Mention the conference to get a rate of $80 per night.

☐**$8.00 – Monday Night Pizza Dinner**

Includes 3 slices of pizza and a soda. *(Please **ADD** $8.00 to your registration cost.)*

CONTACT INFORMATION OF ATTENDEE

First Name:		**Last Name:**
Street Address:		
City:	**State:**	**Zip Code:**
Email Address:		**Phone Number:** ( )

ATTENTION: YOU MUST INITIAL THESE BOXES FOR YOUR REGISTRATION TO BE COMPLETE

To the fullest extent permitted by law, I/we indemnify and hold harmless, the Missouri Department of Mental Health, Missouri Mental Health Foundation, Tan Tar A Resort and Conference Center and their directors, officers, consultants, agents, employees and volunteers from and against all claims, damages, losses and expenses, including but not limited to attorney's fees and court costs, arising out of or resulting from my participation in this event, including damage, loss or expense is attributable to bodily injury, sickness, disease or death, or personal injury, or to injury to or destruction of tangible property or to others involved in the event.

➔ **INITIAL HERE:**___________________

I agree to the production of photographs, recordings, videotapes, or other multimedia projects developed by the Missouri Department of Mental Health and/or, the Missouri Mental Health Foundation, which may include being photographed, recorded, videotaped, or otherwise depicted in such multimedia information. I've been informed that these multimedia projects are being developed to provide an opportunity to educate and inform people about the activities of the Missouri Department of Mental Health and/or the Missouri Mental Health Foundation. I authorize the Missouri Department of Mental Health and/or the Missouri Mental Health Foundation to use any and all of the multimedia information in which I appear and/or are heard without limitation. I acknowledge that the Missouri Department of Mental Health and/or the Missouri Mental Health Foundation will be for all purposes the owner of all rights to the media in which I appear and/or am heard. I agree to hold harmless the Missouri Department of Mental Health, and/or the Missouri Mental Health Foundation, and all their agencies, affiliates, employees, volunteers, agents, successors and/or assigns, against any liability, loss or damage, including attorney's fees, caused by or arising from my appearance in any photograph, record, videotape, or other multimedia information.
I acknowledge that I have not given any other person or organization the exclusive right to use my photograph or any other information about me.

➔ **INITIAL HERE:**___________________

REGISTRATION FORM – Real Voices Real Choices Conference

NAME:

ADDITIONAL INFORMATION

Will you be attending with a group? ☐**Yes** ☐**No**

Group Name:

Name of Group Contact:

Contact Phone Number:
( )

Will you have a Personal Care Attendant?
☐ **YES** ☐ **NO**

Name of PCA:

Please indicate special accommodations: ☐ Braille ☐ Large Print Materials ☐ASL Interpreter

☐ Special Diet: ____

Please list any other accessibility needs:

MEDICAL INFORMATION

➔ **NURSE'S STATION – ON-SITE FIRST AID:**

Basic First Aid and Assessment, ***WITHOUT MEDICATION ASSISTANCE***, *will be available during conference hours. The Basic First Aid area* **will not provide over-the-counter medications** *such as Tylenol, Ibuprofen, topical creams, etc. You will be responsible for these needs.*

- **If medical and assistive devices are needed, you are expected to bring these with you to the conference (for example wheelchair, walker, etc.)**
- **Urinary Incontinence Supplies – If you have problems with wetting the bed, you will need to bring a waterproof mattress pad.**
- **If needed, you are expected to have a caretaker assist you with your needs while attending the conference (for example transfers).**

Emergency Contact Name:

Emergency Contact Phone Number:
( )

Alternate Phone Number:

Please send completed registration via:

Mail:

Missouri Mental Health Foundation
221 Metro Dr., Suite C
Jefferson City, MO 65109

Participant Medical History Form

2017 Real Voices Real Choices

The completion of this form is optional; however, please note that in the case of a medical emergency ***this information would be critical*** to ensure that you receive the most appropriate medical care.

Participant Name: ____ **Age:** _____

Name of Emergency Contact: ____________________________________

Emergency Contact Phone Number: _______________________________

Alt. Phone Number: ____

Allergy Questions		
Do you have any allergies?	**Yes ☐**	**No ☐**
Medication Allergies?		
Food allergies?		
Other allergies?		

General Health Questions			
Do you have any ongoing medical conditions?	**Yes ☐**	**No ☐**	
Please specify below:			
Asthma ☐	**Diabetes ☐**	**Seizures ☐**	**Heart condition ☐**
High Blood Pressure ☐			
Other medical conditions?			
Have you been hospitalized within the last year? Yes ☐	No ☐		
If yes, for what?			
Do you wear glasses or contacts?	Yes ☐	No ☐	
Do you wear hearing aids?	Yes ☐	No ☐	
Please describe the assistive devices you use (i.e. wheelchair, toilet riser, grab bars, etc.)**:**			

Current Medications					
Medication Name	**Dose**	**How often**	**Medication Name**	**Dose**	**How often**