SPECIAL NEEDS FORM

If you have special needs, please carefully read and complete this form. Please submit this form with your group's registration materials.

Youth Gatherings, by their very nature, require that each participant be prepared to navigate significant distances (at minimum, three miles each day) either by walking or with the assistance of the group. Participants walk to and from hotels, around the convention center, and within the location for Stadium Events. Therefore, groups are encouraged to make arrangements for wheelchairs for participants who need them.

The LCMS Youth Gathering will provide reasonable accommodation for individuals with a disability. Participants with limited walking ability or who use wheelchairs need to complete the form below and provide the required information from their health care providers. This information will be used to determine hotel assignments and other arrangements.

Deaf and hard-of-hearing participants and their groups will be provided with sign language interpreters and captioning at all Stadium Events. All participants with mobility impairments and their groups will be notified of special seating prior to the start of the Gathering. There will be no early access provided to Minute Maid Park, the George R. Brown Convention Center or specific events.

Dietary needs, including food allergies, should be discussed with adults in the participant's group and are not to be included on this form.

Indicate

Congregational ID Number: _____

Person Requiring Special Needs: (check one)

☐ Youth ☐ Primary Adult Leader ☐ Adult Leader

Sex: ☐ F ☐ M DOB: _____ /_____ /_____

First Name: _____ Middle Initial: ____

Last Name: _____

Mailing Address: _____

_____

City: _____

State: _____ Zip code: _____

Email: _____

Primary Adult Leader Information

Name: _____

Telephone: _____

Best Time to Call: _____

Email: _____

Briefly state the disability

_____

_____

_____

_____

_____

I give permission to my health care provider (please provide information below) to discuss my son's/daughter's/ward's disability with the Special Needs Team.

_____

Parent/Guardian Signature

Health Care Professional Information

Name: _____

Address: _____

City / State / Zip: _____

Phone Number: _____

Hours available during the work week for phone consultation with the Special Needs Advisor of the Gathering:

_____

Briefly state the above participant's needs while attending the Youth Gathering:

_____

_____

_____

_____

_____

_____

Signature of Health Care Provider

The health care provider should keep a copy of this form in the patient's file.