The 41th International Order of Malta Summer Camp 2026

August 3 – 10, 2026 | Navarra, Spain

Order of Malta Federal Association
U.S.A. Team Guest Application

Submission Deadline: March 1, 2026

Submission Instructions: Please email this completed application to BOTH usateamleadership@gmail.com and FederalAuxiliary@gmail.com

To contact the U.S.A Team Leader, Richard A. Mena, please send an email to **usateamleadership@gmail.com** with any inquiries.

PERSONAL INFORMATION

To complete your application, please provide a recent passport-style photograph. This helps us with identification, travel organization, and preparing delegate materials for Team U.S.A.

Photo Here

Recent Passport – Style Photograph

Head & Shoulder (Only)

GUEST INFORMATION

Guest Name: _____
First Last MI

Date of Birth: _____ /_____ /_____ Age: _____ Gender: _____

Guest Home Address: _____
Street Address

_____
City State Zip Code

Guest Primary Phone #: _____ Guest Email: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____
(if applicable)

I require one-on-one support and will bring an Aid for traveling if selected: ☐ **Yes** ☐ **No**

AID CONTACT INFORMATION (If Applicable)

Aid Full Name: _____

Relationship to Guest: _____

Primary Phone Number: _____

Secondary Phone Number (optional): _____

Email Address: _____

Home Address:_____

City _____ State _____ Zip _____

Will the Aid be traveling with the Guest for the duration of the camp? □ Yes □ No

Does the Aid require separate accommodations? □ Yes □ No

Aid Signature: _____ Date: _____

(This form is to be completed only if a dedicated Aid will accompany the Guest.)

EMERGENCY CONTACT INFORMATION

Primary Contact:

Name: _____ Relationship to Guest:_____

Home Address: _____
(if different than guest)

Primary Phone #: _____ Alt. Phone #: _____

Secondary Contact: (if primary contact is not reached - in case of emergency/illness/injury)

Name: _____ Relationship to Guest: _____

Home Address: _____
(if different than guest)

Primary Phone #: _____ Alt. Phone #: _____

PHYSICIAN INFORMATION

Primary Care Physician: _____

Primary Care Physician Contact Information:

Phone #: _____ Email: _____

Date of last Physical: _____ /_____ /_____

HEALTH INFORMATION

1) **Medications:**

Please ensure that the guest travels with enough of each medication to last the entire time the guest will be with our team. Additionally, please review TSA recommendations for travelling with medications (e.g. if possible, packing original containers labeled with the guest's name and how the medication should be taken, medications packed in carry-on bag and separate from other liquids, and packing extra medication in the event of unforeseen travel delays.

☐ Guest will NOT take any daily medications while attending camp.

☐ Guest will take the following daily medication(s) while at camp:

Medication Name	Reason for taking	Time of Day	Amount / Dose	Method (e.g. orally as pill/liquid, injection, etc.)	Additional Info
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other			
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other			
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other			
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		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other			
		☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other			

2) **Allergies:**

☐ No known allergies. OR ☐ Guest has allergies to: ☐ Food ☐ Medicine

☐ Environmental (insect stings, hay fever, etc.) ☐ Other

3) Please describe **what the guest is allergic to, the resulting reaction, & what intervention is needed (if any) in the case of exposure**

_____

_____

_____

4) Please list any **health conditions** which may **require EMERGENCY ACTION**

Please identify the **condition(s) below, & describe any immediate interventive measures that should be taken until emergency services arrive**

(e.g. seizures, asthma, heart problems, diabetes, allergies, hemophilia, heat exhaustion, etc.)

_____

_____

_____

5) Please indicate which **joints have limited or no range of motion**

☐ Neck / ☐ Spine:			Hips	☐ Left	☐ Right
Shoulders	☐ Left	☐ Right	Knees	☐ Left	☐ Right
Elbows	☐ Left	☐ Right	Ankles	☐ Left	☐ Right
Wrists	☐ Left	☐ Right	Toes	☐ Left	☐ Right
Fingers	☐ Left	☐ Right			

6) Are there any body parts which **CANNOT be moved?** Please describe why.

_____

_____

7) Please note any **sensory difficulties or impairments** which the team should be aware of when interacting (e.g. difficulty hearing in one or both ears, vision, etc.)

_____

_____

8) Please list all **necessary assistive devices** (e.g. glasses, hearing aids, communication devices, orthotic devices, braces, crutches, wheelchair, etc.)

_____

_____

ACTIVITY INFORMATION

1) Check any activities that are **contraindicated** (not allowed).

- ☐ Kneeling
- ☐ Sitting on Floor
- ☐ Moving/Flickering Lights
- ☐ Stretching Body Parts
- ☐ Climbing
- ☐ Heights
- ☐ Massage with Oils
- ☐ Massage with Vibration
- ☐ Tactile Stimuli (feathers, brushing)
- ☐ High-pitched Sounds
- ☐ Swimming
- ☐ Being around animals (Dogs, Cats, Farm animals, Zoos)

2) Please describe if any of the above activities are allowed, **but may cause discomfort, overstimulation, or could serve as a potential trigger**

_____

_____

_____

3) Please describe the **precautions to be taken before participating in an outdoor activity**:

_____

_____

4) Please describe **what, if any assistance the guest may require** with the following activities:

Activity	Self- Sufficient	Needs Assistance (List assistance required)
Eating/ Drinking		
Bathing		
Toilet		
Grooming (Shaving, brushing, Teeth, etc)		
Dressing		
Stairs		

5) Are there any **routines or specific details** regarding the above activities that our team should be aware of? Please describe.

COMMUNICATION INFORMATION

1) Check all **forms of communication** that apply:

☐ Verbal ☐ Body gestures ☐ Facial Gestures

Other: _____

2) Please describe how the guest **expresses him/herself in each situation:**

Situation	Response
Pain/Discomfort	
Anxiety	
Over- Stimulation	
Happiness	
Saying "Yes" to a question	
Saying "No" to a question	

BEHAVIORAL INFORMATION

1) Please list all the behaviors that **may need special attention & how to manage each specific behavior:**

Behavior	Management Technique
Example: Screaming	*Allow a break from the activity*

2) Please list any of the **guest's specific likes and/or dislikes:**

Likes	Dislikes

DIET / NUTRITION INFORMATION

1) **Diet:**

☐ Guest eats a regular diet ☐ Guest eats a vegetarian diet ☐ Guest is lactose intolerant

☐ Guest eats a gluten-free diet (**Please specify:** sensitivity / intolerance / allergy)

☐ Other, please explain below

Please list **all food restrictions** to be considered during the camp (e.g. Gluten, fat, sugar, etc.)

_____

_____

2) If accidentally consumed, what is the **anticipated result & what treatment, action or intervention is needed (if any)?** (e.g. medication, rest, Epi-pen, etc.)

_____

_____

3) Is guest permitted to consume alcohol? ☐ Yes ☐ No.
(There will be alcohol present at some camp activities, but **no guest or volunteer will be required, pressured, or encouraged to consume alcohol.)**

ADDITIONAL INFORMATION:

To my knowledge, all information in this application is accurate and up-to-date.

Signature	Relationship/ Authority	Date

Please email this completed application to BOTH usateamleadership@gmail.com and FederalAuxiliary@gmail.com by March 1, 2026