

Adirondack Arts and Healing Retreats

Creative Healing Connections, Inc.

P.O. Box 545 Saranac Lake, NY 12983

www.creativehealingconnections.org

fran@creativehealingconnections.org

Health Information Form

The following information is necessary for the Retreat Staff to provide emergency first-aid in the field should the need arise. It is also required by hospital medical staff in order to provide secondary care should your injury or illness require evacuation to a hospital. **Please print clearly!**

PLEASE NOTE: If you are a returning participant with no changes, please check here and fill out your name and don't worry about the rest!

Last Name First Name Nickname

Home Address

Home Phone Number Email Address

Birth Date Blood Type Height Weight M/F?

Whom should we notify in case of an accident or medical emergency? Please list an individual who is not attending this program with you.

Last Name First Name Relationship

Home Address Email Address

Home Phone Work Phone

Please give us the name of your health/accident insurance carrier(s) and appropriate policy certificate number(s):

Name of Carrier Policy Number

Name of Carrier Policy Number

Please turn over and fill out other side...

Adirondack Arts and Healing Retreats

P.O. Box 545 Saranac Lake, NY 12983

www.creativehealingconnections.org fran@creativehealingconnections.org

Health History Form – Page Two

Name

Please write as clearly as possible!!

What specific illness(es) bring you to our retreat? _____

Check off any of the following health conditions which apply to you. Describe them on the lines provided below and include any current medications which you take for these conditions:

<input type="checkbox"/> Heart Condition (Angina)	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Bleeding Tendencies
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Hearing Aid
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Asthma	
<input type="checkbox"/> Corrective Eye Lenses	<input type="checkbox"/> Allergies (include plants, insects, medications)	

Please describe: _____

Do you have limited walking ability? (i.e. walk with a cane, walker, wheelchair, use prosthesis, difficulty climbing stairs, etc.) _____

Have you had any operations or serious illness? Please give us dates. _____

Do you have any device that requires electrical power (i.e.: C-PAP machine):

As a result of injury or illness, do you have any implants? (i.e.: a pacemaker, hip joint, hernia screen, etc.) _____

Any chronic or recurring illness or disability regarding any of the following: wrist, neck, ankle, knee, hip, back/spine, shoulder, skull) Please describe:

Can you swim? _____ Do you smoke? _____

Have you had a tetanus booster within the past five years? _____

Because of religious convictions or legal requirements, is there anything we ought to know prior to emergency treatment? (For example, do you have a living will or DNR order? **If so, please bring with you to the retreat.**)

Today's Date _____ **Your Signature** (or typed name if emailing) _____

Please mail or email to: Fran Yardley, Arts and Healing Retreat, P.O. Box 545, Saranac Lake, NY 12983