Creative Healing Connections, Inc.
Adirondack Arts & Healing Retreat
Health Information Form

Participant_____

Address_____

Phone _____Email _____

Do you have limited walking ability, difficulty climbing stairs or accessibility issues? Please specify:

_____

Please let us know of any disabilities or chronic illness that you are currently experiencing that you feel we should be aware of (example, you need an Epipen, you have Asthma, Special Equipment, etc) :

_____

_____

Do you have any dietary restrictions? Gluten or Lactose intolerance? Are you Vegan or Vegetarian?

_____

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.

DOB: HT: WT: Allergies:
_____

Whom should we notify in case of an accident or medical emergency?

_____

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

_____ _____
Name of Carrier Policy Number

Roommate preference: _____

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

Please return this form to CHC, PO Box 165, Saranac Lake, NY 12983
telephone 518 524-6735~ www.CreativeHealingConnections.org