

2009 Participant Health, Information and Registration Form



To ensure your registration is complete please fill out this entire form and return it to the Bluebird Cancer Retreats office along with the Registration Fee. The following information is used to make your weekend stay a comfortable and safe one and will be provided to the staff nurse(s), in addition to the supporting staff. A new Participant Health, Information and Registration Form must be completed each time you participate in a retreat weekend. To ensure your information is kept private, Bluebird Cancer Retreats will destroy this form at the completion of the retreat weekend. Please note: If you and your spouse/significant other are registering for the Couple's Retreat, a separate form must be filled out for each participant.

Today's Date: ____/____/____

Retreat : April Couples May Newcomers September Newcomer October Couples

CONTACT INFORMATION

Name: _____ Age: _____ Male Female

Street Address: _____ City: _____ State: _____ Zip: _____ - _____

Home Phone: () _____ - _____ Alternate Phone: () _____ - _____

E-mail address: _____

DIAGNOSIS AND TREATMENT

Primary Physician: _____ Practice: _____ Phone: () _____ - _____

Oncologist: _____ Practice: _____ Phone: () _____ - _____

Cancer diagnosis: _____ Year diagnosed: _____

Please describe your cancer treatment:

Drugs? _____ Are you currently using these drugs? _____

Chemotherapy? _____ Date of last chemotherapy treatment? _____

Radiation? _____ Date of last radiation treatment? _____

If you are currently receiving treatment, how long have you been receiving it? _____

Please describe anything else relating to your cancer diagnosis that you feel the staff nurse(s) should be aware of:

Do you have any other health concerns that you feel that the staff nurse(s) should be aware of:

Name any allergies and reactions that you have to food or medication:

Are you a diabetic or do you have any dietary restrictions due to medical reasons? If so, please describe them:

Do you need help with medications? Yes No Is refrigeration needed for your medications? Yes No

Please Describe Your Current Medications: (Please use an additional sheet if necessary)

| NAME | DOSAGE | HOW MANY TIMES A DAY? |
|------|--------|-----------------------|
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Do you have medical equipment? No Wheelchair Walker Other_____

Will you require assistance climbing stairs? Yes No

Health Insurance Provider:_____ Policy #:_____ Policy Holder: _____

Primary Hospital: _____

Do you have a designated power of attorney for health care? Yes No

Power of Attorney's Name and Contact Number: _____

Other Information

Birthdate: ____/____/____ T-Shirt Size: _____

What name would like us to call you at Bluebird Cancer Retreats? Do you have a nickname? _____

Sleeping Habits: Light Sleeper Heavy Sleeper I Snore

Roommate Request (if any): _____

Do you have any dietary restrictions due to lifestyle, personal beliefs or religious affiliation? Please describe below.

Please provide information for 2 Emergency Contacts:

Name: _____ Phone number:() _____ - _____

Name: _____ Phone number:() _____ - _____

SIGN UP FOR OUR E-MAIL LIST-SERVE

Would you like to participate in our upcoming email list-serve, keeping you informed of upcoming weekend retreats, opportunities to connect with other retreat participants, volunteer opportunities and Bluebird fundraising events? Your information will not be shared with individuals or companies outside of Bluebird Cancer Retreats. We will keep your information private.

- Yes! Add me to the list now! Ask me at the end of the weekend.

SIGNATURE AND DISCLAIMER

I have completed the above information and acknowledge that the same is true. I acknowledge that I am a voluntary participant and I agree to assume responsibility for myself. I further agree to waive any claims against Bluebird Cancer Retreats, its officers, employees, agents or volunteers resulting from any and all losses, damages, costs and expenses that are caused by or arise out of any act, omission, default, negligence or other misconduct by Bluebird Cancer Retreats, Inc. in connection with this participation.

I acknowledge that the Bluebird Cancer Retreats volunteers are not providing medical or psychological diagnosis, treatment, opinions, referrals, guidance, assistance, or counseling for me specifically, and that these volunteers are present for the purpose of facilitating involvement and not to provide professional services to group participants. I understand that reasonable measures will be taken to safeguard the health and safety of all participants and that my emergency contact will be notified as soon as possible in case of an emergency. In the event they cannot be reached, I hereby authorize Bluebird Cancer Retreats to acquire medical treatment for me.

Finally, I understand that all buildings and grounds are designated as No Smoking and No Alcohol areas.

Signature

Date

CONTACTS:

BlueBird Cancer Retreats
917 W. Savidge #37
Spring Lake, MI 49456
616-847-0839

Renee Denslow, Executive Director
Jan Weiden, Retreat Director