

Health Information and Registration Form



Today's Date: ____/____/____

Retreat : April May September October Reunion

CONTACT INFORMATION

Name: _____ Nickname: _____ Date of Birth: _____ Age: _____ M or F

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

Phone: (____) _____ - _____ Alternate Phone: (____) _____ - _____ E-Mail: _____

Emergency Contact: _____ Phone: (____) _____ - _____

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

Health care power of attorney name and contact number (if applicable): _____

Primary Care Physician: _____ (____) _____ - _____
Name Phone Number

DIAGNOSIS AND TREATMENT

Type of Cancer: _____ Stage: _____ Year Diagnosed: _____

Oncologist: _____ (____) _____ - _____
Name Phone Number Cancer Center

Chemotherapy? Y or N Currently In Treatment? Y or N Name If Known? _____

Radiation? Y or N Currently In Treatment? Y or N Details? _____

Oral Chemotherapy? Y or N currently taking? Y or N Name If Known? _____

Describe anything else relating to your cancer diagnosis that our staff nurse should be aware of: (neuropathy, infections...)

Other health concerns: (diabetes, hypertension, heart conditions...) _____

Allergies and/or reactions to food or medication: _____

Dietary restrictions due to medical conditions, personal beliefs or religious affiliation? _____

LIST YOUR CURRENT MEDICATIONS:

(PLEASE USE AN ADDITIONAL SHEET IF NECESSARY)

NAME	DOSAGE	HOW MANY TIMES A DAY?

Do you have medical equipment? Oxygen Wheelchair Walker Other _____

Do you need assistance with stairs? Y or N

Do you need help with medications? Y or N

Sleeping Habits : Light Sleeper Heavy Sleeper Snore

Roommate Request (If Any): _____

PHOTO CONSENT

I hereby grant to Bluebird Cancer Retreats its agent or assigns, my permission to use my first name, any and all pictures, photographs of or news stories about me for reproduction in any form for, but not limited to, advertising, illustration, television, or scientific publication.

Initial: _____

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 areas.

Signature

Date

Registration Fee Is \$100 Per Person: Enclosed Previously Submitted

HOLISTIC THERAPY QUESTIONNAIRE

As part of your retreat experience, emotional and physical pampering opportunities are offered such as massage, reflexology and healing touch. The following information will be provided to your holistic practitioner for your protection and to allow them to best serve you. Questions with an * are mandatory. This registration form is required for all retreat attendees, including caregivers on couples retreat. Thank you.

Do you have any health issues that you would like to share with your practitioner? _____

*Has your doctor warned you against having deep tissue massage or other body work? _____

*Do you have a history of blood clots? If yes, where in your body? _____

Are there sensitive areas on your body that the practitioner should not touch? _____

Anything else you would like to share? _____

CONSENT FOR THERAPY

I understand that therapeutic massage services are designed to be a health aid and are in no way meant to take the place of a physician's care. Any information exchanged during massage session(s) is educational in nature and is intended to help me become more familiar with and conscious of my own health status.

Signature

Date