Creative Healing Connections, Inc.
Adirondack Arts & Healing Retreats

Health Information Form

Name of Participant _____

Mailing Address _____

City, State, Zip_____ County _____

Phone Numbers _____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 Ashma, 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.

_____/ _____/ _____	_____	_____	_____
Birth Date	Blood Type	Height	Weight

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

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

_____	_____
Name of Carrier	Policy Number

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

Please return this form to CHC, PO Box 165, Saranac Lake, NY 12983
info@creativehealingconnections.com telephone 518-586-1063~~ www.CreativeHealingConnections.org ~~