Fall 2021

Crossroads Emmaus of New England
Medical Information Form

In order to best serve you on this weekend, please complete the following form as part of your registration process.

DEMOGRAPHIC INFORMATION		
Name:		
Date of Birth:		
Current Address:		
City:	State:	Zip Code:
Home Phone: ( )	Mobile Phone: ( )	
Emergency Contact Name:		
Emergency Contact Phone Number: ( )		
Sponsors Name:		
Sponsors Phone Number: ( )		

INSURANCE INFORMATION	
PRIMARY MEDICAL INSURANCE INFORMATION	
Insurance Company Name:	
Insurance Company Address:	
Insurance Company Phone Number:	
Policy Holder's Name:	
Policy Holder's Date of Birth:	
Policy Number:	Group Number:
SECONDARY MEDICAL INSURANCE INFORMATION (IF NEEDED)	
Insurance Company Name:	
Insurance Company Address:	
Insurance Company Phone Number:	
Policy Holder's Date of Birth:	
Policy Number:	Group Number:

ALLERGIES	
Please list all known Allergies, type of reaction and required treatment.	
Food Allergies	
Drug Allergies	
Insect Bite/Sting	
Other Allergies	

MEDICAL HISTORY	
Please indicate below if the participant has any of the following conditions. What is the best way to handle these conditions if needed?	
Diabetes	
Heart Condition	
Asthma	
Chronic Illness	
Other	
Dietary Needs	

Authorization for Treatment:

This health information is correct and complete to the best of my ability. The participant has no physical or mental disabilities that would impair their participation in the weekend retreat except as noted above. In the event of serious illness or injury, I authorize a physician/hospital to undertake such treatment of and perform such services (including surgical) for the participants as are reasonably indicated by the circumstances. I give Crossroads Emmaus New England permission to arrange necessary related transportation for medical treatment.

The health information provided is for the purpose of a safe retreat experience and to meet the health care needs of the participants. The information shall be keep private and confidential, share only as absolutely needed for the health and safety of the participant or with other medical providers in the event of an emergency. This Information will be shredded at the end of the retreat unless otherwise instructed. PLEASE CHECK WHAT YOU WANT US TO DO WITH THIS HEALTH INFORMATION SHEET AT THE END OF THIS RETREAT

☐ SHRED ☐ RETURN TO PARTICIPANT VIA USPS

SIGNATURE: DATE:

TO BE COMPLETED AT REGISTRATION.
Has the participants received and recent medical treatment or Illness? (please describe below):
Has the participant been exposed to a contagious disease or illness?(please describe):