**JUST IN CASE SOMETHING HAPPENS WHILE YOU ARE AWAY ON OUR RETREAT**
**HEALTH FORM AND EMERGENCY AUTHORIZATION**

**Name**_____

**Address**_____**City**_____**State**_____**Zip**_____

**Contact Person**_____

**Phone(H)**_____**Cell**_____

**Significant Medical History: (ie Asthma, Diabetes, Cancer, Heart Disease)**

_____
_____
_____

**Any Allergic Reactions?**

_____
_____
_____

**Current Medications?**

_____
_____
_____

**Medical Insurance:**

**Insurance Company**_____**Policy or Group #**_____

**Address**_____**City**_____**State**_____**Zip**_____

**Phone**_____

**Emergency Authorizations: I give my permission to local Physicians to hospitalize, treat, order injections, anesthesia or surgery if the contact person cannot be reach.**

**Signature**_____**Date**_____

**Please include a copy of your insurance card (Optional)**

**Please fill out this form and seal it in an envelope. Bring it with you to retreat and it will be returned unopened at the end of the event.**