

If yes...Name _____ Age: _____ Relationship: _____

Name _____ Age: _____ Relationship: _____

Name _____ Age: _____ Relationship: _____

Name of Emergency contact _____ Relationship _____

Phone Number of contact: day _____ evening _____

Who has medical power of attorney? _____

Insurance provider _____ Policy Number: _____

Group Number: _____

Dates of coverage: _____

_____ Please initial if you will attend the retreat from Thursday afternoon until Sunday at noon.

If not what dates do you anticipate being in attendance for? _____

We would like to accommodate you if we can so please let us know if you will require a late check-in or early check-out time. _____

Will you require transportation? *Yes No*

If you are driving independently would you be willing to transport another participant?
Yes No

Would you be willing to transport another's luggage in your car to the retreat? *Yes No*

What type of vehicle do you have? _____

Major cross-streets nearest your house: _____

What type or Mobility Aids do you use? *Power Chair Manual Crutches Other*

Can you transfer to a standard seat in a passenger car/van? *Yes No*

Do you require special equipment? *Yes No*

Do you require a specialized mattress? *Yes No*

If yes, what? _____

Can you provide the equipment? *Yes No*

Will you require transportation for your equipment? *Yes No*

How did you hear about the Spinal Cord Injury Retreat? _____

Please check the areas you wish to participate in:

<input type="checkbox"/> Animal interaction	<input type="checkbox"/> Musical	<input type="checkbox"/> Nature/Camping
<input type="checkbox"/> Therapeutic Riding	<input type="checkbox"/> Photography	<input type="checkbox"/> Casino Night
<input type="checkbox"/> Arts and crafts	<input type="checkbox"/> Film	<input type="checkbox"/> Educational Classes
<input type="checkbox"/> Sports	<input type="checkbox"/> Movie night	<input type="checkbox"/> Games
<input type="checkbox"/> Fishing		

Other/Suggestions: _____

Will you need financial assistance in order to attend the retreat? *Yes No*

In the event emergency medical aid/treatment is required due to illness or injury, I authorize the Arizona Spinal Cord Injury Association representatives to assist with my or my minor children's emergency medical treatment and transportation if needed.

Date: _____ Consent Signature: _____

I hereby release the Arizona Spinal Cord Injury Association for any injury or damage I or my minor children may suffer as a result of my and their participation in the "SCI retreat" event. Date: _____ Signature: _____

I consent to and authorize the use and reproduction by the Arizona Spinal Cord Injury Association of any and all photographs and any other audio-visual materials taken of me and my children during the "SCI retreat" event for promotional material, educational activities, fundraising, and exhibitions or for any other use for the benefit of the program without compensation to me.

Date: _____ Consent Signature: _____

Tee shirt size (circle one) S M L XL XXL XXXL

Health History

Date of injury? _____/_____
Month Year

Level of Injury _____ Complete or Incomplete (*please circle*)
Physician(s) Information:

1. Name of Primary Care Provider: _____

Address: _____ Phone #: _____

2. Name of Specialty Care Provider: _____

Address: _____ Phone #: _____

Do you see a doctor routinely? Y / N

Date of last appointment? _____/_____
Month Year

Current SCI related health problems?

Have there been any emergency room visits or hospitalizations for spinal cord related problems within the last year? Y / N

Reason for ER visit hospitalization _____

Are you currently under a doctor's care for any other health problems? Y / N

Please describe:

Caregiver Requirements

Do you require assistance getting into and out of your wheelchair? Y / N

Do you require assistance getting dressed? Y / N

Do you require assistance with grooming/bathing? Y / N

Do you require assistance to eat/drink? Y / N

Urinary management method:

Foley/Suprapubic/Condom catheter

Intermittent self-catheterization

Other: _____

Do you require assistance with bladder management? Y / N

Do you require assistance with bowel management? Y / N

If yes, how often? _____ Method used: _____

Do you require assistance to turn during the night? Y / N

If yes, how often? _____

Please list all medications you are taking, including over the counter medications.

Name of Medication	Dosage	How often

Are you allergic to any medications?

Medication	Reaction	Date of last reaction

Are you allergic to latex or latex products? Y / N

Are you allergic to any foods, animals/insects?

Food/Animal/Insect	Reaction	Date of last reaction

Health Database

Do you have any if the following? *Please circle:*

Neurological

Autonomic Dysreflexia
Dizziness/fainting
Epilepsy/seizures
Headaches/migraines
Neuropathy
Stroke, transient ischemic attacks
Anxiety/Depression
Psychiatric or Emotional Illness
Thought process/memory impairment
Sleep problems
Sleeping medications

Cardiovascular

Heart dysrhythmias
Coronary artery disease/heart attack
Congestive heart failure
Pacemaker
Implanted defibrillator
Valve disease/murmur
Deep vein thrombosis

Respiratory

Shortness of breath
Sleep apnea
COPD/emphysema
Asthma
Cough
Home oxygen
Do you smoke? Y / N

Gastrointestinal

Heartburn
Blood in Stools
Nausea/Vomiting
Diarrhea
Liver disease

Genitourinary

Bladder or prostate disease
Frequent urinary infection
Kidney disease

Pain

Chronic pain

Endocrine

Type I Diabetes
Type II Diabetes
How is it controlled? (circle)
Diet
Medications
Insulin/Insulin pump
Home glucose monitoring
How often? _____
Thyroid disease

Skin

Areas of redness
Open sores
Location _____

If any of this information changes between the time of application and the Spinal Cord Injury Retreat, please call Micaela at the Arizona Spinal Cord Injury Association: (602) 239-5929