

Reeling and Healing, Inc.
Participant Registration Form
(All inquiries and information is confidential)

Name: _____ Birth Date: _____ Age: _____
Name to use on Name Tag: _____ Email: _____
Address: _____ City: _____
State/Zip: _____ Home Phone: _____ Work Phone: _____
Retreat Date: _____ Scholarship Request: _____
Physician's Name: _____ Phone: _____
Date of Last Appointment: _____ Type of Cancer and Year diagnosed: _____
Date Cancer Treatment Completed: _____
Cancer Treatment: Radiation Chemo Hormone Therapy
Allergies: (Food or Medicine): _____ Reaction: _____

Do you need help with medications? (please circle one) Yes No
Is refrigeration needed? (please circle one) Yes No

Current Medications: Please see attached.

Dietary Restrictions and Requirements: _____

Do you have any General Restrictions or Special Needs? _____

Sleeping Habits: Light Sleeper: ____ Heavy Sleeper: ____ Snore: ____ Sleep Walker: ____
Roommate Request: _____

Boot Size: _____ Hip Size: _____ Height: _____

Are you interested in car pooling (please circle one): Yes No

What is your previous fishing experience, if any: _____

How did you hear about Reeling and Healing: _____

List 2 (if different from power of attorney) Emergency Contacts:

Do you have a designated power of attorney for health care? (please circle one) Yes No If yes, Name: _____
Phone: _____

Name: _____

Phone: _____

Name: _____

Phone: _____

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 Reeling & Healing, Inc., its officers, employees, agents or volunteers

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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 Reeling & Healing, Inc. in connection with this participation.

I acknowledge that the Reeling & Healing 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 Reeling & Healing to acquire medical treatment for me.

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

Signature: _____ Date: _____

NOTE: Once completed, this form may be returned by one of the following methods:

Scan/e-mail: jwalle@findleydavies.com
Mail: Reeling & Healing, Inc.
c/o Judy Walle
5137 Newhart Circle, Toledo, OH 43615

For your registration to be complete and to receive final confirmation, you must submit the Retreat Registration Form (Form 1), the Participant Medical Permission Form (Form 2), and your registration fee of \$75, if you have not requested a scholarship.

If you have any questions concerning the retreats contact Judy Walle at 419-327-4146 (day), 419-536-2469 (evening), or (jwalle@findleydavies.com).

We look forward to having you at the retreat!

For Staff Use
Only

Retreat date: _____
Reg Form: Y or N Reg Fee: Y or N
Conf Pack: Y or N Med Staff: Y or N
Initial: _____