

MEDICAL/EMERGENCY INFORMATION 2012

Required information by all who attend:

Name: _____ Session _____

Name of personal caregiver coming (if applicable):

Age: _____ Gender: _____ Weight: _____ Date of birth: _____

Medications: Please check one of the following:

- I take no medications.
- I take medications and will self-administer them. Please list all medications below. List each one, reasons for taking and number of times per day needed.

Health History (Indicate any conditions we should know about including diabetes, heart trouble, epilepsy, kidney disease, sleep walking, etc.)

Serious illnesses or operations (list and explain during the last 5 years)

List any conditions that could affect your participation in our programs

Traveling Needs/Physical Limitations

- Does participant have a disability (beside vision) or chronic disease? Please explain:

- Does participant use a white cane? _____
- Does participant use a wheelchair? _____
- Able to take care of personal grooming (independently) Yes___No___

Oral Hull Foundation , PO Box157, Sandy, OR 97055, oralhull@teleport.com, 503-668-6195

○ Daily shower (independently)? Yes_____No_____

Meals/Diet

- I am a vegetarian
- I have special dietary needs. Please specify:_____
- I have a medically prescribed diet. Please specify:_____

Allergies to medications, environment (insect stings, hay fever, or food)_____

Emergency Contact Person for Medical Issues:

1. Name_____Relationship_____

Address_____

Cell phone _____Work phone_____Home phone_____

2. Name_____Relationship_____

Address_____

Cell phone_____Home phone_____

Physician to consult in cases of accident or emergency

Name_____Phone_____

Hospital/Medical Office name_____

Medical Insurance Company_____

Policy and or group #_____Phone_____

What have we forgotten to ask? Please provide any additional information that you may think important or that may affect your ability to participate in our programs.

Please note: Over-the-counter medicine such as aspirin, Tylenol, Pepto-bismol, etc., must be supplied by the participant.

This health history is correct so far as I know and the person herein described his/ her permission to engage in all activities, except as noted. I hereby consent to any radiological procedure, examination, anesthetic, medical/surgical diagnosis/treatment, and hospital service that may be rendered under the general/special instruction of above named physician/any hospital, or at Oral Hull. This consent shall remain in continuous effect until revoked in writing. A photocopy of this authorization shall be considered as effective and valid as the original. The Oral Hull Foundation does not provide health/accident insurance for participants. Participants must carry their own insurance or be prepared to pay the cost of any medical services or prescriptions obtained while at Oral Hull.

Signature _____ Date _____

COMPLETE RELEASE AND HOLD HARMLESS AGREEMENT

By my signature on this document, I assume all liability from any cause whatsoever that may arise, out of or in connection with, Oral Hull Foundation for the Blind, Inc. including, but not limited to all liability from any cause whatsoever, for personal injury or property damage; in connection with, or during the time of my presence, at any businesses or other enterprise of this nonprofit organization.

I release and hold harmless the Oral Hull Foundation for the Blind, Inc., its employees, agents, volunteers, assigns, and successors (hereinafter, "the protected parties") from all liability from any cause whatsoever as described above.

The consideration for this document is the services that the Oral Hull Foundation for the Blind is providing to me. This document shall be given a liberal construction, with all ambiguities resolved in favor of the protected parties. If any provision of this document is deemed to be partially void, invalid, or unenforceable, that provision shall continue in full force and effect to the maximum extent permitted by law, and all remaining provisions of this document is deemed to be completely void, invalid, or unenforceable, that provision shall be served from the remainder of this document, and all remaining provisions of this document shall continue in full force and effect.

Name (print) _____

Signature _____ Date _____