



# Survivor Retreat Application

Contact Information			
Last Name	First Name	Preferred Name	Gender
Street Address	City	Zip	
Birthdate (dd/mm/yyyy)	Cell Phone	Email	
Emergency Contact Name	Cell Phone	Relationship	
Retreat Information			
Diet:	Food allergies:	Special diet needs e.g. soft food, gluten-free	
Activity:	Do you use a <u>walker or cane</u> ?	Can you walk one block without stopping?	
	<input type="checkbox"/> Yes      No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Have you fallen in the last 6 months?	Are you able to walk on uneven surfaces?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Yes	<input type="checkbox"/> No	
Are you able to walk up a hill for 10 minutes?	How many times per day do you need to rest or nap?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3 <input type="checkbox"/> more
Sleeping:	Do you have a C-Pap or Bi-Pap?	Do you use oxygen at night?	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

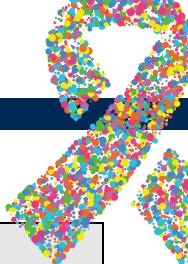
I will contact the Survivorship Coordinator if I am experiencing any cold or flu-like symptoms or issues related to treatment the week of the retreat.

Signature \_\_\_\_\_

I give my permission for my physician/mid-level provider additional information regarding my participation at the retreat.

Signature \_\_\_\_\_

<b>Medical Information</b>			
Cancer Diagnosis:	Cancer stage:		
Have you completed your cancer treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you continuing treatment for metastatic cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of treatment closest to April 26, 2026:	
Oncologist's name:	Oncologist office address:		
<b>MEDICATION ALLERGIES</b>	<b>DESCRIBE YOUR REACTION</b>		
<b>BEE STING ALLERGY</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, do you have a prescription for an EPI pen? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Other Medical Conditions</b>			
Current (like an infection) and chronic (long term like diabetes or asthma)			
<b>Medication List</b>			
If you need more lines continue on to page 3.			
Name of medication	Reason for taking	Dose	Times of Day
<b>Important Note:</b> If you have an inhaler or epi pen, you <b>MUST</b> bring them and carry them with you <b>AT ALL TIMES.</b>			



## Medication List Continued

**Important Note:** If you have an inhaler or epi pen, you **MUST** bring them to the retreat and carry them with you **AT ALL TIMES**.

**Please email all 3 completed pages of the application to:**

Kymberly.Duncan@northside.com as soon as possible.

**The last day applications will be accepted is March 13, 2026.**