

**GETTING STRONGER TOGETHER  
2005 OHIO SELF-ADVOCACY RETREAT  
MEDICAL INFORMATION FORM**

**Please fill out this form and return it with your Retreat Registration information and payment.**

**Name** \_\_\_\_\_

**Phone Number** ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Birth Date:** \_\_\_\_\_

**Social Security #** \_\_\_\_\_

**Medications:**

<b>MEDICINE</b>	<b>DOSE/ ADMINISTRATION INFORMATION</b>	<b>WHEN YOU TAKE IT</b>	<b>NEED HELP? (YES/NO)</b>

**\*If you need more space, please check here and continue on back of page \_\_\_\_\_.**

**Allergies:** \_\_\_\_\_

**Special Diet:** \_\_\_\_\_

**(PLEASE CONTINUE ON NEXT PAGE)**

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**Medical of Physical Concerns:**

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**Doctor's Name:** \_\_\_\_\_

**Doctor's Phone #:** ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

**Dentist's Name:** \_\_\_\_\_

**Dentist's Phone #:** ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

**Health Insurance Company & Policy Number:**

\_\_\_\_\_

**Medicaid #:** \_\_\_\_\_

**Medicare #:** \_\_\_\_\_

**Preferred Hospital:** \_\_\_\_\_

**Emergency Contact Information:**

**Name:** \_\_\_\_\_

**Phone #:** ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

\*If unable to contact my emergency contact, you have my permission to obtain medical treatment from a licensed doctor or dentist and/or transport me to a hospital in the event of an emergency.

Signature: \_\_\_\_\_ Date signed: \_\_\_\_\_

Guardian's Signature (if applicable): \_\_\_\_\_

Date signed: \_\_\_\_\_