MEDICAL CONSENT FORM

I _____, am aware that
Print Caregiver's Name

_____ DOB ___/___/_____
Print patients Name

wishes to participate in an JCCSG Retreat.

I know of no reason why she should not be able to participate.

Caregiver's Signature: _____

Print Name: _____

Date: ____/____/_____

Caregiver's Phone Number: _____

In case of emergency, where can the JCCSG reach you?

Cell Phone: _____ Email: _____

We won't share it with anyone, and will not use it, only in case of emergency…

Participants Details:

First name:_____ Last name: _____

Address: _____

Tel: Home_____ Mobile_____

Date of birth: ___/_____/_____

Emergency Contact:

First name:_____ Last name:_____

Address:_____

Tel: Home_____ Work_____ Mobile_____

Relationship: _____

Health Care Details:

General Doctor's Name:

_____ Tell: _____

GI Doctor's Name:

_____ Tell: _____

Surgeon's Name:

_____ Tell: _____

Other Doctors:

_____ Tell: _____

_____ Tell: _____

Medical Information:

Can you describe your Condition: Crohn's / Colitis (please circle)

What else can you tell us about your condition?_____

_____

_____

_____

_____

_____

_____

_____

Current / Past Medications

Name	Dose	Frequency	Physician	Purpose	Current?

Surgical Procedures

Date	Procedure	Physician	Hospital	Notes

Additional Medical Details:

Do you have any allergies? yes / no (please circle)

If yes, please list:_____

_____

_____

Please list any additional medical conditions that you have (for example, asthma, diabetes, etc.):

_____

_____

To the best of my knowledge, all information contained on this form is correct

Signature:_____

Print Name: _____

Date: _____