

STATEMENT OF PHYSICAL, MENTAL & PSYCHOLOGICAL HEALTH CONDITION

All information provided on this form is kept confidential.

| Name: | | | | |
|------------------|----------|---|----------------|--|
| Age: | | | | |
| Sex: | M | F | | |
| Telephone: | | | | |
| EMERGENCY (| CONTACT: | | Name | |
| | | | Cell Number(s) | |
| EMERGENCY NOTES: | | | | |
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1- Please list any physical limitations, disabilities, issues, allergies, conditions, past injuries or any other concern that could limit your participation on the retreat:



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| 2- | What medications are you taking or will you take during the retreat? Please list any precautions and side effects. |
|----|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 3- | Have you been diagnosed with depression, schizophrenia, bi-polar disorder, epilepsy or any other behavioral, mental and/or psychological conditions? |
| 4- | Do you have a history of initiating or perpetuating sexual, emotional or physical abuse? Do you have a history of substance abuse? Do you have a history of suicidal tendencies or a suicide attempt? |
| 5- | If I should warrant immediate medical attention on this retreat, I hereby grant permission to the medical personnel, selected by the journey guides, to review my personal records or to contact the appropriate physician, psychiatrist, health professional or psychologist to obtain additional information on the conditions noted. |



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| – Pa | rticipant's signature Date | | |
|---------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| Pl€ | Please add your initial to the left of each item and then sign below: | | |
| 9- | I declare these statements are correct to the best of my knowledge. | | |
| 8- | I agree to adhere to the decision by QE3 Synergies, Renee Hutcherson Lucier, CMC and/or its representatives, regarding the suitability of my participation in the excursion. | | |
| 7- | If I should warrant immediate medical attention on this retreat, I hereby grant permission to the physician selected by QE3 Synergies, Renee Hutcherson Lucier, CMC and/or its representatives to hospitalize, secure proper treatment for, and order injections and/or anesthesia for, and/or surgery for me. | | |
| 6- | If I should warrant immediate medical attention on this retreat, I hereby grant permission to the medical personnel, selected by the host and/or retreat guides to order x-rays, routine tests and treatment for me in the event the emergency contact cannot be reached. | | |