



**FRIDAY, OCTOBER 8TH TO
SUNDAY, OCTOBER 10TH 2010 AT
LOON LAKE**

**Deadline for Applications:
FRIDAY, September 3rd 2010**

PLEASE RETURN COMPLETED FORMS BY
MAIL OR FAX TO:

Retreat Coordinator
#614 – 1033 DAVIE ST
VANCOUVER BC, V6E 1M7

Fax: 604-684-3126

NAME	TELEPHONE	BIRTHDATE
ADDRESS	CITY	POSTAL CODE

May we leave a message at this number? ----- Yes No

May we state the name of the organization (PWN)?----- Yes No

Have you ever attended a PWN retreat? ----- Yes No

If yes, when did you LAST attend a PWN retreat? -----
Month, year

Do you have transportation to Vancouver (PWN)?----- Yes No

Do you have transportation directly to retreat site? ----- Yes No

Do you have a car you could use to carpool with other
members from your area? (Your costs would be reimbursed)----- Yes No

Will you need a childcare subsidy?
If so, please read the enclosed child-care policy ----- Yes No

Is there a specific person you would like to share a room with at the retreat? _____
Name

Name(s) and age(s) of child(ren) and who they live with:

NAME	AGE	WHO THEY LIVE WITH



- Are you a vegetarian? ----- Yes No
- Are you a vegan? ----- Yes No
- Do you eat pork? ----- Yes No
- Do you eat beef? ----- Yes No
- Do you eat chicken? ----- Yes No
- Do you eat fish?----- Yes No
- Do you eat seafood/shellfish? ----- Yes No
- Do you eat dairy?----- Yes No
- Do you eat eggs?----- Yes No

Do you have food allergies? Please describe _____

Do you require nutritional supplements such as Advera or Ensure (please specify)? If you request a nutritional supplement for the retreat, please see the nurse when you arrive at the retreat site.

Anything else you would like us to know?

We will do our best to accommodate these needs, but we cannot make any promises!

The Positive Women's Network respects your privacy, and is committed to protecting your personal information. PWN has policies and procedures that conform to the requirements of the BC Personal Information Protection Act (PIPA). The information you provide to PWN on this form will be maintained as a secure, confidential record. PWN maintains appropriate safeguards regarding the privacy of members, volunteers, supporters, and staff. Please contact us if you wish to see our complete PWN Privacy Policy.



INSTRUCTIONS:

PLEASE COMPLETE PAGES 1 & 2 OF THIS MEDICAL FORM AND EITHER MAIL OR FAX THIS FORM (IN ADDITION TO YOUR REGISTRATION FORMS) TO #614-1033 DAVIE ST., VANCOUVER, BC, V6E 1M7 OR FAX: 604-684-3126 BY **FRIDAY, SEPTEMBER 3RD 2010.**

SIDE ONE, TO BE COMPLETED BY YOU	1.	FIRST NAME	INITIAL	LAST NAME	CARD CARD NUMBER (OPTIONAL)
	2.	IN CASE OF EMERGENCY, NOTIFY	RELATIONSHIP TO YOU	PHONE NUMBER	DOES THIS PERSON KNOW YOU HAVE HIV/AIDS? YES <input type="checkbox"/> NO <input type="checkbox"/>
	3.	LIST ANY MEDICAL CONDITIONS, INCLUDING ALLERGIES, ASTHMA, ETC., THAT YOU FEEL WE SHOULD KNOW ABOUT			

4.	LIST THE MEDICATIONS/TREATMENTS YOU ARE CURRENTLY USING				

5.	<p>For the safety of all members, we will not tolerate the use of recreational drugs or alcohol during the retreat weekend. We will not tolerate sharing or selling of any drugs such as methadone, medicinal marijuana, etc., during the retreat weekend. If you are using medicinal marijuana or methadone, please indicate below. You must be discreet in your use of medicinal marijuana, and, if smoked, it must be used outdoors. The use of medicinal marijuana or methadone must be doctor approved on page two of this form.</p> <p>DO YOU USE MEDICINAL MARIJUANA? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>DO YOU USE METHADONE? YES <input type="checkbox"/> NO <input type="checkbox"/></p>				
6.	APPLICANT'S SIGNATURE			DATE	

IMPORTANT FOR YOU TO KNOW

1. THIS INFORMATION WILL ENSURE YOU RECEIVE THE BEST CARE POSSIBLE IF YOU BECOME ILL OR INJURED DURING THE RETREAT.
2. A COMMUNITY HEALTH NURSE WILL BE PRESENT AT THE RETREAT SHOULD YOU REQUIRE ANY MINOR CARE OR HAVE ANY MEDICAL QUESTIONS.
3. ALL INFORMATION ON THESE FORMS IS KEPT CONFIDENTIAL AND WILL BE SHARED ONLY WITH THE PWN STAFF AND THE RETREAT NURSE.
4. TRANSPORTATION TO THE NEAREST HOSPITAL WILL BE AVAILABLE SHOULD A MEDICAL EMERGENCY ARISE.
5. IT IS YOUR RESPONSIBILITY TO ENSURE THAT BOTH THIS FORM, AND THE DOCTOR'S FORM, ARE FILLED IN COMPLETELY AND SENT TO PWN.
6. THIS INFORMATION IS SHREDDED AFTER THE RETREAT. WE WILL NOT KEEP THESE FORMS ON FILE UNLESS YOU REQUEST THAT WE DO SO.



APPLICANT NAME:

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SIDE TWO, TO BE FILLED OUT BY YOUR DOCTOR

1	TB TESTS	B.C. TB CONTROL HAS INFORMED US THAT HIV+ PEOPLE SHOULD ALWAYS HAVE A CHEST X-RAY TO CONFIRM TB STATUS. ALSO, IF CD-4 COUNT IS LESS THAN 400, THE TB SKIN TEST MAY BE INACCURATE.			
		1 HAS THE APPLICANT HAD A NEGATIVE TUBERCULIN SKIN TEST AND/OR A NEGATIVE CHEST X-RAY WITHIN THE LAST YEAR? . Yes <input type="checkbox"/> No <input type="checkbox"/>			
		2 HAS THE APPLICANT HAD A POSITIVE TUBERCULIN SKIN TEST? Yes <input type="checkbox"/> No <input type="checkbox"/>			
		3 DOES THE APPLICANT HAVE ACTIVE TB? Yes <input type="checkbox"/> No <input type="checkbox"/>			
		4 IS SHE CURRENTLY RECEIVING TREATMENT FOR TB? Yes <input type="checkbox"/> No <input type="checkbox"/>			
		5 IF YES, HAS SHE COMPLETED TREATMENT? Yes <input type="checkbox"/> No <input type="checkbox"/>			
2	CONTROLLED SUBSTANCE	PLEASE COMPLETE THIS SECTION IF THE APPLICANT IS USING A CONTROLLED SUBSTANCE, INCLUDING MEDICINAL MARIJUANA OR METHADONE.			
			SUBSTANCE USED	DOSE	SIDE EFFECTS
		A			
		B			
		C			
3	IS THIS APPLICANT MEDICALLY FIT TO ATTEND A WEEKEND RETREAT OUTSIDE OF THE LOWER MAINLAND? (THERE IS A NURSE ONSITE BUT NO DOCTOR.)				
	COMMENTS				
	<hr/> <hr/> <hr/> <hr/>				
4	PHYSICIAN'S SIGNATURE AND STAMP		PHYSICIAN'S NAME (PLEASE PRINT)		

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