



ILLUMINATING  
PATHS

**From Where I Stand: Exploring A Spiritual Landscape  
A Pilgrimage to the Black Hills of South Dakota  
September 18-26, 2010**

**Health History and Authorization for Emergency Medical Treatment**

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

**Health Information**

The following information and all data on this form will be held in confidence and given only in an emergency to a medical doctor and/or medical facility not having access to your medical history.

Components of the pilgrimage may be mildly strenuous including walking tours each day. Should you choose, you have the option to not participate.

**Date of Birth:** Month \_\_\_/ Day\_\_\_/ Year\_\_\_\_\_

**Health Issues** (check all that apply): \_\_\_ Asthma \_\_\_ Diabetes \_\_\_ Seizures \_\_\_ Kidney Disease \_\_\_ Convulsions \_\_\_ Heart Disease \_\_\_ Other (specify):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medications currently taken (include dosage):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Date of Last Tetanus Vaccine:** \_\_\_\_\_

**Physical Impairments:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Other Health Conditions or Concerns.** Mention health information that may be used in presenting your situation to a medical provider in the event of a medical emergency. Be specific.

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**Health Insurance Information**

Provider: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Policyholder's Name: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Emergency Contact Information: \_\_\_\_\_

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**Authorization for Emergency Medical Treatment**

I, \_\_\_\_\_, subject to the conditions set forth below, consent to receive such medical treatment and/or surgical procedures as are deemed necessary in the event of an emergency and to assume liability for any medical expenses involved. Should a medical emergency arise during my participation on pilgrimage, I understand that reasonable efforts will be made to reach the emergency contact person listed on my Travel Information Form. If it is believed my life or health may be adversely affected by a delay that attempting to reach my emergency contact person might cause, I consent to: (i) the administration of medical treatment and/or surgical procedure deemed necessary by the medical doctor and/or medical facility chosen by the pilgrimage leadership; and (ii) the immediate administration of life-sustaining measures deemed necessary under the circumstances.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Fax completed form to: 888.253.3393 or scan and e-mail to:  
pilgrimage@illuminatingpaths.com**