



Metastatic Breast Cancer Retreat

September 18-20, 2026

Patient Application

GENERAL INFORMATION		
PLEASE PRINT NEATLY		
Last Name:	First Name:	Preferred Name:
Street Address		
City:	State	Zip:
Preferred Contact Number:	Alternate Number:	Date of Birth:
Email Address (please print neatly —this is extremely important):		Preferred way to contact:
Who is the support person you are bringing and your relationship?:		
EMERGENCY CONTACT		
Name:	Relationship:	
Preferred Contact Number:	Alternate Number:	
RETREAT INFORMATION		
The following information will help us make sure you are able to enjoy your time while at the retreat.		
Food Allergies:		
Food Preferences (Vegetarian, etc.)		
Do you use a walker/cane?	Can you walk one block without stopping?	
Do you have a C-Pap or Bi-Pap?	Do you use oxygen at bedtime?	
Do you have any other limitations we should be aware of?		

MEDICAL INFORMATION

Cancer Diagnosis:	Cancer stage:
Are you currently in treatment? Yes / No If yes, what kind of treatment? Chemo Radiation	Date of treatment closest to August 9th:
Physician's name:	Treatment location:

MEDICATION ALLERGIES		TYPE OF REACTION
BEE STING ALLERGY	Yes / No	If yes, do you have a prescription for an EPI pen? Yes / No

OTHER MEDICAL CONDITIONS
Current (like an infection) and chronic (long term like diabetes)

MEDICATION LIST
(if you need more space, use a separate sheet of paper)

Name of medication	Reason taking	Dose	Times of day

Date of last Tetanus or Tdap vaccine:

Important Note: If you have allergies or asthma, you **MUST** bring your own epi pen and inhaler(s) and carry them with you **AT ALL TIMES** during the retreat.

I give my permission for my physician/mid-level provider to provide any additional information for my participation in the retreat.

Signature _____ Date _____

TO BE COMPLETED BY PHYSICIAN OR MID-LEVEL PROVIDER

Care Provider Authorization:

By signing this form, you are telling us that, in your opinion, this person is both physically and emotionally ready to participate in the Metastatic Breast Cancer Retreat Friday, September 18 - Sunday, September 20, 2026.

The following restrictions apply to my patient (if none, so state):

Care Provider's (MD/APP) Signature _____ Date _____

Printed Name _____

Send completed application by August 7, 2026 to:

Kymerly.duncan@northside.com