



The Beat Retreat 2024 Application Form

APPLICATION DEADLINE: August 1, 2024



Personal information		
Full name:		
D.O.B. (dd/mm/yyyy):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary	
Street address:		Apt.:
City:	Province:	Postal Code:
Home phone:	Cell phone:	
Email:	Health card number:	
What is your swimming level: <input type="checkbox"/> Beginner <input type="checkbox"/> Intermediate <input type="checkbox"/> Advanced <input type="checkbox"/> Can't swim		
Medical Contacts		
Family doctor		
Name:		
Office phone:	Pager number:	
Cardiologist		
Name:		
Office phone:	Pager number:	
Hospital affiliation:		
Medical information		
<u>NOTE:</u>		
<ul style="list-style-type: none">You must attach a printed copy of your most recent clinic letter and ECG to this application. If you have a pacemaker, you must also attach a printout showing your latest PPM readings.If you are a non-resident of Canada, you must also provide the following no later than August 1, 2024:<ul style="list-style-type: none">A photocopy of your passport ID page showing your full name, picture and date of birth.Proof that you will have full medical coverage (travel health insurance) during your stay in Canada.		
Do you have any major allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please specify:</i>		
Do you carry an Epi Pen? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you wear a Medic Alert bracelet? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Please list any major health concerns (other than your congenital heart condition):		
Do you have any dietary restrictions? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please specify:</i>		
Do you have any special physical needs? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please specify:</i>		

Emergency Contact Information		
Primary contact		
Name:		
Relationship:	Home phone:	
Business phone:	Cell phone:	
Street address:		Apt:
City:	Province:	Postal code:
Secondary contact		
Name:		
Relationship:	Home phone:	
Business phone:	Cell phone:	
Street address:		Apt:
City:	Province:	Postal code:

Release and waiver of liability and indemnity agreement	
<p>I understand and acknowledge that attending The Beat Retreat a camp established for congenital heart disease patients, has inherent risks (health, safety, and/or otherwise) that may be higher for people with congenital heart disease. I also understand that a requirement for attending The Beat Retreat, and participating in camp activities, is relinquishing any and all rights to hold The Beat Retreat liable for any injury or damage I may suffer while attending The Beat Retreat and participating in The Beat Retreat's camp activities.</p> <p>KNOWING THIS, I HEREBY VOLUNTARILY RELEASE THE BEAT RETREAT AND CANADIAN CONGENITAL HEART ALLIANCE ("CCHA") FROM ANY AND ALL LIABILITY RESULTING FROM OR ARISING OUT OF MY ATTENDING THE BEAT RETREAT AND/OR PARTICIPATING IN ANY CAMP ACTIVITIES.</p> <p>I understand and agree that I am releasing not only The Beat Retreat and CCHA, but also its Directors, Officers, Agents, and Volunteers. I understand and agree that this Release Agreement will have the effect of releasing, discharging, waiving and forever relinquishing any and all actions or causes of action that I may have or have had, whether past, present or future, whether known or unknown, and whether anticipated or unanticipated by me, arising out of my attending and/or participating in the activities offered at The Beat Retreat. THIS RELEASE CONSTITUTES A COMPLETE RELEASE, DISCHARGE AND WAIVER OF ANY AND ALL ACTIONS OR CAUSE OF ACTION AGAINST THE BEAT RETREAT and CCHA, AND ITS DIRECTORS, OFFICERS, AGENTS AND VOLUNTEERS.</p> <p>I understand and agree that this Release Agreement applies to personal injury, property damage, or wrongful death, which I may suffer, even if caused by the acts or omissions of others, or is related to any new or pre-existing medical condition I may have. I am aware that some of the activities offered at The Beat Retreat – including but not limited to volleyball, canoeing, swimming, ropes course, archery, climbing wall, campfires and/or initiatives games – involve many risks and hazards that could result in death or injury, and that the risk of death or injury may be higher for someone with congenital heart disease. I have been advised that I need to seek medical advice if I know or suspect that my physical condition may be incompatible with any of the activities offered.</p> <p>I understand and acknowledge that while attending The Beat Retreat, I will be fully responsible for monitoring my own healthcare (i.e., taking medications as prescribed; ensuring my activity level is appropriate based on my medical history and condition). I FURTHER UNDERSTAND AND ACKNOWLEDGE THERE WILL NOT BE ANY DESIGNATED MEDICAL PERSONNEL ON SITE DURING THE BEAT RETREAT NOR AT THE CAMP FACILITY WHERE THE CAMP RETREAT IS HELD AND THAT THE CAMP RETREAT IS NOT EQUIPPED WITH AN EXTENERAL DEFIBRILLATOR. I also understand and acknowledge that the nearest hospital is Grand River Hospital. I understand that this hospital is approximately 20 minutes away and does not have a cardiologist who specializes in congenital heart defects.</p> <p>I understand and acknowledge that by signing this Release Agreement, I am assuming full responsibility for any and all risk of death or personal injury or property damage suffered by me while attending The Beat Retreat. I understand and agree that this Release Agreement will be binding on me, my spouse, my heirs, my personal representatives, my assignees, my children and any guardian ad litem for said children. I understand and agree that by signing this Release Agreement, I am agreeing to indemnify and hold The Beat Retreat, CCHA, its Directors, Officers, Agents and Volunteers harmless from any and all liability or cost including attorneys' fees, associated with or arising from my attending The Beat Retreat. I ACKNOWLEDGE AND UNDERSTAND THAT I HAVE READ THIS RELEASE AGREEMENT AND THAT I UNDERSTAND THE WORDS AND LANGUAGE IN IT. I HAVE BEEN ADVISED OF THE POTENTIAL DANGERS INCIDENTAL TO MY ATTENDING THE BEAT RETREAT.</p>	
Applicant's name:	
Applicant's signature:	Date:
Witness' name:	
Witness' signature:	Date:

Photo and Video Release

I hereby consent to:

- The Beat Retreat and CCHA, its authorized agents and its volunteers collecting, taking, producing, transmitting, broadcasting and/or disclosing photographs, films and/or sound recordings of me (or any other audio and/or visual reproductions of me) while I am attending The Beat Retreat.
- The Beat Retreat and CCHA using those photographs, video images and voice recordings for:
 1. educational purposes
 2. publication in print or on the Internet
 3. presentation at fundraising events for The Beat Retreat and CCHA.

I understand, acknowledge and hereby waive any claim for payment arising from the use of any images, recordings or information for the purposes noted above.

I AGREE to the terms outlined in this photo and video release.

I DO NOT AGREE to the terms outlined in this photo and video release (lack of consent will not preclude my participation in camp activities).

Applicant's name:

Applicant's signature:

Date:

Privacy

The Beat Retreat and CCHA knows that confidentiality of personal information is important. That said, by completing and signing this form I hereby authorize the following:

- The Beat Retreat and CCHA to hold and use as appropriate and necessary information on my medical condition and history.
- The Beat Retreat, CCHA, its authorized agents and volunteers to use that medical information – and to share it with members of the medical community – as appropriate and necessary to provide me with emergency medical care while attending The Beat Retreat and while participating in camp activities (including transportation to and from the camp).

I also hereby verify that the information provided by means of this form is – to the best of my knowledge – true and complete.

Applicant's name:

Applicant's signature:

Date:

COVID-19

A reminder that COVID 19 could be very harmful to those in our group. If you are experiencing any symptoms such as fever, chills, sore throat, fatigue prior to camp then please do not attend.

Let's all do our part to keep everyone safe. We ask that you please sanitize your hands frequently during your camp stay. Some participants may not be comfortable with close contact such as hugging, so please be respectful.

I ACKNOWLEDGE AND AGREE TO THE COVID-19 TERMS NOTED ABOVE.

Applicant's name:

Applicant's signature:

Date:

Registration fees and donations

There is a \$150 registration fee for attending the Beat Retreat. Please attach a cheque for \$150 to your application. The cheque should be made out to Canadian Congenital Heart Alliance ("CCHA"). You may also send an e-transfer to thebeatretreatcamp@gmail.com. If you have any questions or concerns regarding the registration fee please contact Toby Cox (647-549-1198) immediately. Tax receipts are not provided for registration fees.

If you can afford more than the \$150 registration fee, we urge you to make a donation to the Canadian Congenital Heart Alliance to help offset costs. If you wish to make a donation (this is an amount over and above the \$150 registration fee), please send a second (separate) cheque made out for the desired amount. Please write "Beat Retreat Donation" in the memo line. The Beat Retreat will be able to issue tax receipts for donations above \$20.00.

PLEASE BE SURE TO ATTACH THE REQUIRED DOCUMENTS:

- A PHOTOCOPY OF YOUR PROVINCIAL HEALTH CARD.
- A COPY OF YOUR MOST RECENT CLINIC LETTER AND ECG.
- A PRINTOUT OF YOUR LATEST PPM READINGS, IF YOU HAVE A PACEMAKER.
- A BEAT RETREAT MEDICAL FORM FILLED OUT BY YOUR CARDIOLOGIST. IF YOU HAVE PROBLEMS GETTING YOUR CARDIOLOGIST TO COMPLETE THE FORM, CONTACT US IMMEDIATELY; WE WILL DO OUR BEST TO ASSIST.
- A PHOTOCOPY OF YOUR PASSPORT ID PAGE AND PROOF OF TRAVEL MEDICAL COVERAGE, IF YOU ARE A NON-RESIDENT OF CANADA
- EMAIL: thebeatretreatcamp@gmail.com
- MAIL: 497 Silverthorn Ave., Toronto, Ontario, M6M 3H8



The Beat Retreat – 2024 Medical Form



Attendee information <i>(to be completed by attendee)</i>		
Full name:		
D.O.B. (dd/mm/yyyy):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary	
Street address:		Apt.:
City:	Province:	Postal Code:
Home phone:	Cell phone:	
Email:	Health card number:	

Cardiologist Opinion *(to completed by cardiologist.)*

Dear Cardiologist:

Your patient is planning to attend The Beat Retreat camp, a four (4) day weekend camping retreat for adult congenital heart patients. This retreat is being held at the YMCA Camp Ki-Wa-Y, a camp accredited with the Ontario Camps Association, located approximately 20 minutes north of Kitchener, Ontario. Attendees will have an opportunity to participate in a number of traditional camp activities, including but not limited to canoeing, climbing wall, low ropes, archery, volleyball, badminton, yoga, massage therapy, etc.

During the camp, attendees will be responsible for monitoring their own health and care (i.e., medications, activity level). NO designated medical personnel will be available on site. The nearest hospital is Grand River Hospital, approximately 20 minutes away.

As adults, **attendees will be expected to use their judgment and participate (or abstain) from activities as appropriate based on their physical limitations and comfort level.** Kindly provide your opinion on any limitations or restrictions the above-noted attendee has in relation to their participation in any camp activities.

Medical Opinion

I have examined the above camp participant. Date of last examination: *DD / MM / YYYY*

In my opinion, the above applicant **is** / **is not** able to participate in an active camp program.

Please indicate any limitation, restrictions or concerns for participation in camp activities.

Cardiologist's Contact Information

Cardiologist's name:

Phone number:

Signature:

Date:

Attendee authorization for release of medical & personal information *(to be completed by attendee)*

I hereby authorize the release of the medical information requested on this form to The Beat Retreat, CCHA, and any medical practitioners as deemed appropriate and/or necessary to help ensure my safety while attending The Beat Retreat. I ALSO AGREE TO RESPECT AND ABIDE BY THE LIMITATIONS AND RESTRICTIONS AS OUTLINED IN THE MEDICAL OPINION ABOVE.

Applicant's name:

Applicant's signature:

Date:

The Beat Retreat Medical Information Form

This information is for Medical personnel only. It will be used in case of Emergency for Ambulance transfer and Hospital admission. Hard copy will be made to be used if needed. These copies will be destroyed once The Beat Retreat is over for the year and will be updated next year if you attend.

Full Name:

List all congenital and acquired conditions, eg. Tetralogy of Fallot, diabetes 2.

List all Cardiac and non-cardiac procedures, eg. Closure of patent foramen ovale, tonsillectomy.

Most recent INR results?

How often do you get your INR checked?

List all medications, dosage, frequency, time of day taken.

Anything additional you wish to add?