



Has the Walk to Emmaus been explained to you? *(circle answer)*

YES / NO

Have Share Groups and Monthly Gatherings been explained to you? *(circle answer)*

YES / NO

State briefly why you want to attend the Walk to Emmaus: \_\_\_\_\_

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**PARTICIPANT'S SPECIAL NEEDS AND MEDICAL INFORMATION (kept on site for the event)**

Participant's Name: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_  
Street City/State/Zip

Primary Care Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Please list all allergies to medications: \_\_\_\_\_

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If the participant brings any medications (prescription or over the counter) to the Emmaus Walk, please bring a list that contains each medication, along with dosage and frequency.

If you require any other type of medical attention for any pre-existing medical condition, please provide the necessary information on a separate piece of paper so proper care can be provided during the Emmaus Walk.

Do you have any dietary restrictions or concerns (i.e., vegetarian, diabetic, food allergies, etc.):

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Do you have any other allergies? If so, please explain: \_\_\_\_\_

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Please describe any mobility or ability concerns (assistance, trouble with stairs, difficulty hearing, etc.):

Do you have any sleeping concerns (apnea, use C-PAP, heavy snoring)? If so, explain: \_\_\_\_\_

Please share any additional information regarding special needs or medical health that you feel the Team should know about: \_\_\_\_\_

### **AUTHORIZATION FOR MEDICAL TREATMENT**

In the unlikely event that medical intervention is necessary for the Participant, every attempt will be made to contact the individual designated as "Emergency Contact Person." Only if that person cannot be reached in an emergency during the Emmaus Walk for which permission has been granted for the Participant to participate, I hereby give my permission to the Emmaus Leadership Team to hospitalize at preferred hospital (or any hospital reasonably accessible), secure medical treatment and order any injection, anesthesia or surgery for myself as deemed necessary. I understand that I am liable for any expenses incurred due to emergency treatment. I understand all reasonable safety precautions will be taken at all times by the Greater Cincinnati Emmaus Community and its agents during the Walk sponsored by same. I understand the possibility of unforeseen hazards and know the inherent possibility of risk. I agree not to hold Greater Cincinnati Emmaus Community, its Board of Directors, its leaders, employees or volunteer staff liable for damages, losses, diseases or injuries by the subject of this form.

Print Participant's Legal Name: \_\_\_\_\_

Participant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please submit a deposit of \$25 to be applied to the total cost of \$125. Pay online at <https://cincinnatiemmaus.org/participant-fees> or checks payable to Greater Cincinnati Emmaus. This deposit is non-refundable but may be transferred to another Emmaus Community. A deposit is required to secure a place 'in line'.

Scan this application and email to: [register@cincinnatiemmaus.org](mailto:register@cincinnatiemmaus.org)

or

Mail along with Sponsor's application and deposit to:  
Emmaus Walk Registrar c/o St. Paul Community UMC  
8221 Miami Ave., Madeira, Ohio 45243