Our Lady of Confidence Retreat Registration & Medical Profile Form

October 13-15, 2026

This retreat is for adults with intellectual disabilities.

Cost: For the Our Lady of Confidence Retreat, payment is not required. We ask each participant to consider a donation to Malvern Retreat House. Please make checks payable to Malvern Retreat House.

* Required

Retreatant Information

Retreatant First and Last Name *

Registration (today's) date: *

Address (include street address, city, state and zip code) *

Retreatant Date of Birth *

Gender: *

- ◯ Male
- ◯ Female

Cell Phone Number

Home Phone Number

E-mail address

I have attended Our Lady of Confidence Retreat in the past: *

- ◯ Yes
- ◯ No

Institution Name (if applicable)

Parish Name (if applicable)

Medical Insurance Company:

Medical Insurance Group:

Member ID #:

Do you have any pre-existing medical conditions? *

- ◯ Yes
- ◯ No

Please specify what kind of medical condition(s) you have. If none, please type N/A. *

Are you currently taking any medications? *

- ◯ Yes
- ◯ No

List all medications including the name, strength and dosage below OR e-mail a list of medications to opd@archphila.org - please write "E-mailed" below so we can confirm receipt of medication list.

If none, please type N/A, *

Accommodations - check all that apply: *

- ☐ Walker
- ☐ Wheelchair
- ☐ ASL interpreter
- ☐ Sighted Guide
- ☐ Braille Material
- ☐ One-on-One Escort
- ☐ Special Diet
- ☐ None

If special diet is necessary, please describe:

Will you be staying over night for the duration of the retreat? *

- ◯ Yes
- ◯ No

Assistance Needed *

- [ ] Personal Hygiene
- [ ] Getting Dressed
- [ ] Toileting
- [ ] Taking Medications
- [ ] None
- [ ] Other

Will retreatant be bringing a support staff person to assist with any needs? *

- ◯ Yes
- ◯ No

If yes, please provide support person's name, phone number and relation to retreatant.

Please note ALL support staff will need to complete a support staff registration form: https://forms.office.com/Pages/ResponsePage.aspx?id=Od5I9WW_f02HHQfUzb6QzOciYex9IR9EkzNInbZNzNRURTVLTk01MU43VVVTUzBXWjdBRVhaMUNUUS4u

How does the retreatant best share his/her needs? *

- ◯ Verbal communication
- ◯ Augmentative/alternative communication device
- ◯ American Sign Language
- ◯ Tactile American Sign Language
- ◯ Other

Special Instructions or Comments:

24 Hour Contat

In case of a medical emergency

Emergency Contact Name *

Emergency Contact Phone Number *

Relationship: *

Photo Release Permission

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By writing your name below, you indicate that you agree to the photo release permission statement above.

Today's Date *