Team Number: ________________

MEDICAL FORM

This form is OPTIONAL. Please complete the below information in the event that you have a medical condition that may affect your race. All information is confidential and is used only by our Medical Crew in the event of an emergency.

Name: ____ Sex: __________________

Address: ____

Birthdate: _______________________ Health Care No. __________________________

Do you have any past injuries or medical conditions that may influence your race?

____

____

Have you had surgery in the last twelve months? If so, describe

____

Current Medications: ____

____

Allergies (to medication or other): ____

____

Do you carry an epi-pen for any of these allergies? _____________________________

Emergency contact: Name: _________________________ Phone No. ______________