



MEDICAL INFORMATION FORM FOR COMPETITORS/SUPPORT/VOLUNTEERS

All Team Members, Support Personnel and Volunteers must read, complete and sign this form. Please list all information requested. **Please print.**

SECTION I – PERSONAL INFORMATION

TEAM NAME: _____ NUMBER: _____

DOB: _____ SEX: M ___ F ___

NAME: _____
LAST FIRST M.I.

HT: _____ WT: _____

ADDRESS: _____
STREET

EMERGENCY CONTACT

NAME: _____

CITY, STATE or PROVINCE, COUNTRY

PHONE: _____

PHONE NUMBER: _____

RELATIONSHIP: _____

SECTION II – MEDICAL HISTORY

Are you currently taking any type of prescription or over the counter medication?

YES ___ NO ___

If "YES", please list names and dosages.

Are you allergic to any type of **medication**?

YES ___ NO ___

If "YES", please list. _____

Do you currently have or have had a history of any of the following?

	YES	NO		YES	NO		YES	NO
Allergies (food, dust, etc.)			Dizzy/Fainting			Joint Problems		
Allergies (insect bite)			Epilepsy			Kidney Problems		
Arthritis			Eye Problems			Major Surgery (within 3 yrs)		
Asthma			Cold Injuries			Malaria		
Back Problems			Headaches			Mononucleosis		
Blood in Stool			Hearing Problems			Nausea / Vomiting		
Blood in Urine			Heart Problems			Numbness in Limbs		
Blurred Vision			Hepatitis (what type)			Respiratory Problems		
Bronchitis			Hernia			Stomach Problems		
Cancer			High/Low Blood Pressure			Tuberculosis		
Diabetes			Hyper/Hypothyroidism			Other not Listed		

If "YES" to any of the above, please explain. _____

What is your Blood Type / RH Factor? _____

