



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. _____