

# MEDICAL INFORMATION FORM

## COMPETITORS / SUPPORT CREWS / VOLUNTEERS

All Team Members and Support Personnel complete and sign this form. Please list all information requested.

### SECTION I: PERSONAL INFORMATION

TEAM NAME \_\_\_\_\_  
 FIRST \_\_\_\_\_ LAST \_\_\_\_\_ M.I. \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 PHONE NUMBER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
 HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ SEX \_\_\_\_\_  
 EMERGENCY CONTACT: \_\_\_\_\_  
 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 name & dosage.

Are you allergic to any type of medication? YES \_\_\_\_\_ NO \_\_\_\_\_ If "YES", please list.

Do you have or have you had a history of any of the following: (If yes, explain below.)

|                         | NO | YES |                       | NO | YES |                       | NO | YES |
|-------------------------|----|-----|-----------------------|----|-----|-----------------------|----|-----|
| Allergies (food, dust)  |    |     | Dizzy/Fainting        |    |     | Kidney Problems       |    |     |
| Allergies (insect bite) |    |     | Epilepsy              |    |     | Major Surgery (3 yrs) |    |     |
| Arthritis               |    |     | Eye Problems          |    |     | Malaria               |    |     |
| Asthma                  |    |     | Cold Injuries         |    |     | Mononucleosis         |    |     |
| Back Problems           |    |     | Headaches             |    |     | Nausea/Vomiting       |    |     |
| Blood in stool          |    |     | Hearing Problems      |    |     | "Nerve" Problems      |    |     |
| Blood in urine          |    |     | Heart Problems        |    |     | Numbness in Limbs     |    |     |
| Blurred Vision          |    |     | Hepatitis (what type) |    |     | Respiratory Problems  |    |     |
| Bronchitis              |    |     | Hernia                |    |     | Stomach Problems      |    |     |
| Cancer                  |    |     | High/Low B/P          |    |     | Tuberculosis          |    |     |
| Hearing Loss            |    |     | Hypothyroidism        |    |     | Other Not Listed      |    |     |
| Diabetes                |    |     | Joint Problems        |    |     |                       |    |     |

IF "YES" to any above, please explain: