



Medical Form

Participant Name			
		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of Birth (MM/DD/YYYY)	Age		Weight lbs / kgs.

Emergency Contact Name	Relationship	Daytime Phone	Evening Phone
Primary Physician Name	Practice / Hospital	Daytime Phone	Evening Phone
Insurance Company Name	Policy Number	Group Number	

Do you have any of the following ?

<input type="checkbox"/> epilepsy / seizures	<input type="checkbox"/> bleeding / clotting disorder	<input type="checkbox"/> heart disease
<input type="checkbox"/> asthma / emphysema	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> diabetes

<input type="checkbox"/> allergies	<input type="checkbox"/> medications	<input type="checkbox"/> special needs	<input type="checkbox"/> medical history
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List details, including which medications need refrigeration, below. Use the back of this form if you need more space.

Signature	Date

<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>	MEDS	<input type="checkbox"/>	OTHER
OFFICE USE ONLY					
			Last Name		
			Participant Number		

On-Event Emergency Contact