CHARLOTTESVILLE, VA → WASHINGTON, DC
HIV/AIDS VACCINE BIKE TREK 2017
SEPTEMBER 27 - 30

Medical Form

Participant Name

Date of Birth (MM/DD/YYYY) | Age | ☐ Male ☐ Female | 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 ?

☐ epilepsy / seizures ☐ bleeding / clotting disorder ☐ heart disease

☐ asthma / emphysema ☐ high blood pressure ☐ diabetes

☐ allergies ☐ medications ☐ special needs ☐ medical history

List details, including which medications need refrigeration, below. Use the back of this form if you need more space.

Signature | Date

On-Event Emergency Contact

OFFICE USE ONLY

☐ ALLERGIES ☐ MEDS ☐ OTHER

Last Name

Participant Number

Charity Treks, Inc.
P.O. Box 321
Charlottesville, VA 22902

ChartyTreks
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www.charitytreks.org