

Uptown Macon Rotary **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: _____ Team 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	N	O		YES	N	O				
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?

Do you wear eyeglasses/contact lenses? Females -

YES ___ NO ___ Are you, or could you be pregnant? YES ___ NO ___

If "YES", do you have spare glasses/contacts or a copy of If "YES", when is your "due date"?

_____ your prescription?

YES ___ NO ___ When was your last menstrual period? _____

SECTION III – HEALTH CARE PROVIDER AND INSURANCE INFORMATION

NAME: _____ PHONE NUMBER: ADDRESS: _____

INSURANCE CARRIER: POLICY NUMBER: GROUP NUMBER: Please attach a copy of your insurance card to the back of this form. (This is for the purpose of having this information available if you must be transported and/or hospitalized by an agency outside of Uptown Rotary Ocmulgee Adventure Race. All medical care provided by Uptown Rotary Ocmulgee Adventure Race medical personnel are provided to you with no direct fee.)

I, _____, verify that the above information is true and correct, to the best of my knowledge. I understand that Uptown Rotary Ocmulgee Adventure Race will uphold patient confidentiality and safeguard my medical and personal information. I understand that I have the right to refuse medical treatment, except where the law allows for Implied Consent Treatment. I understand that Uptown Rotary Ocmulgee Adventure Race provides this medical care to me with no direct fee. I understand that Uptown Rotary Ocmulgee Adventure Race medical personnel will make medical treatment and transport decisions that are based solely on what is in my best medical interest.

Signed: _____ Date: _____

OFFICE USE ONLY BELOW THIS LINE

UPTOWN ROTARY OCMULGEE ADVENTURE RACE MEDICAL REVIEW AND NOTES

EVENT: DATES:

REVIEWED BY: _____

DATE: _____