

# 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		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: \_\_\_\_\_