Individual Medical Form

Team Number & Name:_____

First Name: _____Surname:_____

Home Address:_____

Date of Birth: _____ Sex: M F

Are you currently taking any medications? yes no
If so, please specify :_____

Are you allergic to any medications? yes no
If yes, please specify:_____

Please list any allergies you have (insects, food...) and if you are currently being treated for them (ie: do you have an Epi Pen ?):

_____

Do you have Diabetes? yes no Are you insulin dependant? yes no Are you diet controlled? yes no

Have you been treated for any serious illnesses within the last three years? If yes, please describe:

_____

Have you recently experienced or been diagnosed with any of the following? (circle those which apply):

shortness of breath	heart racing	headaches
asthma	COPD	epilepsy
dizziness	high blood pressure	heart palpitations
numbness in limbs	low blood pressure	chest pains
nausea/vomiting	blurred vision	loss of hearing
blood in urine	blood in stool	hypothyroid
hyperthyroid	tuberculosis	hepatitis (which type?)

Have you had any surgeries or surgical procedures within the last three years? If yes, please describe:

_____

Is there anything else pertaining to your health that we should know about (ie chance of being pregnant)?

_____

Name, address and phone number of your doctor: _____

_____

Name, and phone number of the person we contact in case of emergency? What is their relationship?

_____

Health Card number, or Insurance Provider & policy # if from out-of-country:_____

I certify that I am physically fit, have sufficiently trained for participation in the Wilderness Traverse Adventure Race, and have not been advised otherwise by a qualified medical person. I also certify that all the information given above is correct.

Signature: Date: