OPTIONAL RUNNER MEDICAL HISTORY

Please complete this and turn in at the Runner Check-In

This is for the Event Medical Staff only. No one else has access to this information and this form will be destroyed after the race. It will not be used for any other purpose other than to help us provide medical treatment should the need arise. Our goal is the same as you: to get you safely to the finish line!

NAME____

Team #_________ Team Name ___________________

M_____F_____ AGE_____

Please list any medical conditions that you have:

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Please list any medications you are taking, including vitamins and supplements:

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Do you have any allergies to any medications? Yes_______ No_______

If yes, please explain____

Please provide contact information for one person who is not at the race whom we may contact in case of an emergency:

Name_______________________________________ Phone_____________________