

OPTIONAL RUNNER MEDICAL HISTORY

****Please complete this and turn in at the Runner Check-In if you have anything to report.**

This is for the 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 Name _____

M _____ F _____ AGE _____

Please list any medical conditions that you have:

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

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 _____