



# 2009 Participant Medical & Emergency Contact Form

(must be completed and submitted with entry)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Physical Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Blood type: \_\_\_\_\_ Last Tetanus Shot: \_\_\_\_\_

Allergies: \_\_\_\_\_

Regular Medications: \_\_\_\_\_

Medical Problems: \_\_\_\_\_

(Heart disease, high blood pressure, kidney disease, diabetes, etc.)

Please list all major surgeries in the past 5 years: \_\_\_\_\_

Please circle all that apply: Contact Lenses      Glasses      Dentures      Other: \_\_\_\_\_

Are you an organ donor?      YES      NO      Specific Organs? \_\_\_\_\_

Do you have medical insurance?      YES      NO

If yes, please complete the following:

Company Name: \_\_\_\_\_ Policy No.: \_\_\_\_\_

## **Emergency Contact:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Physical Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Relationship: \_\_\_\_\_

Will he/she be at track?      YES      NO      Work Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_