

Medical History Form

BIB Number:

Name: _____ DOB: _____

Emergency contact information:

Name: _____ Phone: _____

Name: _____ Phone: _____

Have you ever had, or are now being treated for any of the following?

	Yes	No	When
Heart Disease			
High Blood Pressure			
Seizure			
Asthma/Lung Disease			
Liver Disease			
Kidney Disease			
Diabetes			
	Yes	No	List
Drug Allergies			
Current Medication			
Surgery last 5 years			
Are you allergic to bee stings?			

If any of these medical problems should develop between the time you submit your entry form and race day, please alert race management so that we may be aware of the situation.

I hereby declare that the answers to the above questions are as true and accurate as possible.

Signature: _____ Date: _____

This information will either be returned to the individual listed above at the conclusion of the event or will be shredded by race officials.