MEDICAL INFORMATION

Volunteer's Name:

This completed medical information form will help each cyclist and volunteer have as safe and healthy a ride as possible. This information is **confidential** and will, in case of a medical emergency, allow HABITAT 500 staff to act swiftly and confidently in obtaining emergency assistance. Each participant must sign the following consent to medical care and treatment. (A parent or guardian must sign the consent for a cyclist who is a minor).

In case of an emergency, notify: ____________________ Relationship: ____________________

Address: ____________________

Daytime Phone: ____________________ Evening Phone: ____________________

Medical Insurance Company: ____________________ Policy #: ____________________

Family Doctor: ____________________ Phone Number: ____________________

Special Instructions: ____________________

Please indicate if you have been affected by any of the following;

Allergies	Y__N__Date___	High/Low Blood Pressure	Y__N__Date___
Asthma	Y__N__Date___	Hypoglycemia	Y__N__Date___
Back Pain	Y__N__Date___	Hypothermia/Frostbite	Y__N__Date___
Blurred/Double Vision	Y__N__Date___	Memory Loss	Y__N__Date___
Broken Bones	Y__N__Date___	Menstrual Problems	Y__N__Date___
Chemical Use/Abuse	Y__N__Date___	Neck Pain	Y__N__Date___
Concussions	Y__N__Date___	Numbness in Hands/Feet	Y__N__Date___
Diabetes	Y__N__Date___	Pulmonary/Cerebral Edema	Y__N__Date___
Digestive Problems	Y__N__Date___	Ringing in Ears	Y__N__Date___
Dizziness	Y__N__Date___	Seizures/Convulsions	Y__N__Date___
Epilepsy	Y__N__Date___	Sprains	Y__N__Date___
Fears (height, dark, etc.)	Y__N__Date___	Ulcers	Y__N__Date___
Hallucinations	Y__N__Date___	Unconsciousness	Y__N__Date___
Heart Problems	Y__N__Date___	Weakness of Limbs	Y__N__Date___
Hernia	Y__N__Date___	Other ___________________	Y__N__Date___

Emotional upsets (date and why): ____________________

Hospitalizations (date and why): ____________________

Current medications/reason: ____________________

Current prescribed medications: ____________________

If you are presently affected by any of the above, please give more detailed information below. You will not be denied access to the bike ride because of this information. We are concerned with being able to provide you with the proper care if the need arises.

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"I hereby authorize the release of the medical information above to medical personnel if deemed necessary by the HABITAT 500 staff. I also authorize all medical, diagnostic, surgical, and hospital procedures as may need to be performed by a treating physician. This authorization is given in advance of any specific diagnosis, treatment, or hospital care being required and is in effect for the duration of the event."

I have read the information on this form and certify that the information I have provided is accurate and correct. I authorize its release to medical personnel if deemed necessary by the HABITAT 500 Staff.

______________________________ ______________________________ __________

Participant's Signature Parent's Signature if Minor Date