

# MEDICAL INFORMATION FORM

Name and Rider #:

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).

## Emergency Contact #1:

In case of an emergency, notify: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

## Emergency Contact #2:

In case of an emergency, notify: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

## Medical Contact:

Medical Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Family Doctor: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Special Instructions: \_\_\_\_\_

## MEDICAL INFORMATION:

Birth Date	Age	Height	Weight	Male / Female Gender (circle)
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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__	Ring 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.

## WAIVER:

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