

MEDICAL INFORMATION

Cyclist's 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).

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.

"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