MEDICAL INFORMATION FORM
FOR
COMPETITORS/VOLUNTEERS

All Team Members, and Volunteers must read, complete and sign this form. Please list all information requested. **Please print.**

SECTION I – PERSONAL INFORMATION

TEAM NAME: ___________________________ Team Number: ________

NAME: ________________________ ________________________ _____
LAST FIRST M.I.

ADDRESS: ____
STREET

____
CITY, STATE or PROVENCE, COUNTRY

PHONE NUMBER: ____

DOB: ______ SEX: M ____ F ____

HT: ___________ WT: __________

EMERGENCY CONTACT

NAME: __________________________

PHONE: _________________________

RELATIONSHIP: __________________

SECTION II – MEDICAL HISTORY

Are you currently taking any type of prescription or over the counter medication?
YES ___ NO ___
If "YES", please list names and dosages.

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Are you allergic to any type of **medication**?
YES ___ NO ___
If "YES", please list. _____________________________

____

Do you currently have or have had a history of any of the following?

	YES	NO		YES	NO		YES	NO
Allergies (food, dust, etc.)			Dizzy/Fainting			Joint Problems		
Allergies (insect bite)			Epilepsy			Kidney Problems		
Arthritis			Eye Problems			Major Surgery (within 3 yrs)		
Asthma			Cold Injuries			Malaria		
Back Problems			Headaches			Mononucleosis		
Blood in Stool			Hearing Problems			Nausea / Vomiting		
Blood in Urine			Heart Problems			Numbness in Limbs		
Blurred Vision			Hepatitis (what type)			Respiratory Problems		
Bronchitis			Hernia			Stomach Problems		
Cancer			High/Low Blood Pressure			Tuberculosis		
Diabetes			Hyper/Hypothyroidism			Other not Listed		

If "YES" to any of the above, please explain. ____

____

What is your Blood Type / RH Factor? ______________________________

Do you wear eyeglasses/contact lenses? YES ___ NO ___ If "YES", do you have spare glasses/contacts or a copy of your prescription? YES ___ NO ___	Females - Are you, or could you be pregnant? YES ___ NO ___ If "YES", when is your "due date"? ________________ When was your last menstrual period? _____________

SECTION III – HEALTH CARE PROVIDER AND INSURANCE INFORMATION

NAME: ____ PHONE NUMBER: _________________________________

ADDRESS: ____

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INSURANCE CARRIER: ____

POLICY NUMBER: ___________________________________ GROUP NUMBER: ______________________________

Please attach a copy of your insurance card to the back of this form.

(This is for the purpose of having this information available if you must be transported and/or hospitalized by an agency outside of Checkpoint Adventures, LLC (CPADV). All medical care provided by CPADV medical personnel are provided to you with no direct fee.)

I, ____, verify that the above information is true and correct, to the best of my knowledge. I understand that Checkpoint Adventures, LLC will uphold patient confidentiality and safeguard my medical and personal information. I understand that I have the right to refuse medical treatment, except where the law allows for Implied Consent Treatment. I understand that Checkpoint Adventures provides this medical care to me with no direct fee. I understand that CPADV medical personnel will make medical treatment and transport decisions that are based solely on what is in my best medical interest.

Signed: ____ Date: _______________________

OFFICE USE ONLY BELOW THIS LINE

STAFF NOTES

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EVENT: ____ DATES: _________________________

REVIEWED BY: ____ DATE: _______________