

**Please fill in all information with a ballpoint pen:**

NAME \_\_\_\_\_ AGE \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY/STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**PLEASE CHECK  ALL ITEMS WHICH APPLY TO YOU.**

**Contact Lenses:  YES  NO**

<b>HAVE YOU EVER EXPERIENCED?</b>	<b>ALLERGIES</b>	<b>MEDICAL CONDITIONS</b>	<b>MEDICATIONS</b>
<input type="checkbox"/> Chest pain	<input type="checkbox"/> HAYFEVER	<input type="checkbox"/> Heart Attack, Angina	<input type="checkbox"/> Nitro Glycerin (or other)
<input type="checkbox"/> Dehydration	<input type="checkbox"/> DRUGS	<input type="checkbox"/> Abnormal Heart Rhythm	<input type="checkbox"/> Anti-Arrhythmics
<input type="checkbox"/> Muscle Cramps	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Beta-Blocker
<input type="checkbox"/> Heat Exhaustion	<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diuretic (water pills)
<input type="checkbox"/> Heat Stroke	<input type="checkbox"/> _____	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Insulin (or pills)
<input type="checkbox"/> Hypoglycemia	<b>FOOD</b>	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Anti-Epileptics
<input type="checkbox"/> Hypothermia	<input type="checkbox"/> Nuts	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Anti-Coagulants
<input type="checkbox"/> Hyperventilation	<input type="checkbox"/> Shellfish	<input type="checkbox"/> Asthma	<input type="checkbox"/> Ventolin
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Strawberries	<input type="checkbox"/> Anemia	<input type="checkbox"/> Iron Pills
<input type="checkbox"/> _____	<input type="checkbox"/> MSG	<input type="checkbox"/> Recent Infections	<input type="checkbox"/> Anti-Biotics
	<input type="checkbox"/> _____	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Anti-Histamines
	<input type="checkbox"/> BEE STINGS	<input type="checkbox"/> Recent Surgery	<input type="checkbox"/> _____
	<input type="checkbox"/> _____		<input type="checkbox"/> _____

**Emergency Contact on Race Day**

Family/Friend \_\_\_\_\_ Phone \_\_\_\_\_

DOCTOR \_\_\_\_\_ Phone \_\_\_\_\_

If from out of town - Hotel Name \_\_\_\_\_