



PARTICIPANT Medical Form

Wheel to Heal 2010

Name: _____

Bib Number: _____

1. Any surgery or serious medical issues in the last three years: No , Yes If yes, please describe: _____
2. Allergic to any medications: No , Yes If yes, please describe: _____
3. Heart Problems: No , Yes If yes, please describe: _____
4. Diabetes: No , Yes If yes, please describe: _____
5. Asthma: No , Yes If yes, please describe: _____
6. High/Low Blood Pressure: No , Yes If yes, please describe: _____
7. Allergies: No , Yes If yes, please describe: _____

8. List any other medical condition/s that would be of concern performing your role/participating in the ride: _____

To the best of my knowledge, all of the above questions have been answered accurately as possible. **Must be signed.** (If under the age of 19, a Parent or Guardian signature is required)

Signed this _____ day of _____ 2010

Participant Signature

Participant Print Name

Parent or Guardian Signature
(if participant is under 19)

Parent or Guardian Name

Witness Signature

Witness Printed Name