

# W2H PARTICIPANT MEDICAL FORM

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:

\_\_\_\_\_

9. Emergency Contact Information:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

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 \_\_\_\_\_ 20\_\_\_\_

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Participant Print Name

\_\_\_\_\_  
Parent or Guardian Signature  
(if participant is under 19)

\_\_\_\_\_  
Parent or Guardian Name

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Witness Printed Name