



## COMPETITOR MEDICAL FORM

*(Please answer all questions)*

1. Are you currently taking any medications (prescription/OTC)? Please specify types/amounts:
2. Are you allergic to any medications? If yes, please specify:
3. Please list any other allergies you have (food, hay fever, dust) and if you are being treated for them:
4. Have you been treated for any serious illnesses within the last three years? If yes, please describe:
5. Have you recently experienced or been diagnosed with any of the following? (Circle those that apply)

shortness of breath	heart racing	headaches
dizziness	high blood pressure	heart palpitations
numbness in limbs	low blood pressure	chest pains
nausea/vomiting	blurred vision	loss of hearing
blood in urine	blood in stool	mononucleosis
hypo-thyroid	hyper-thyroid	tuberculosis
hepatitis (which type)	epilepsy or seizures	

6. Have you had any surgeries or surgical procedures within the last three years? If yes, please describe:
7. Do you wear eyeglasses or contact lenses? (please circle which)
8. Is there anything else pertaining to your health that we should know about? If so please explain.
9. Name of current Health Care Provider; please **attach copy of insurance card** (insurance carrier):  
(If you do not currently have insurance, please acknowledge)

Subscriber Identification Number:

10. Please provide the name, address and telephone number of your doctor:

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Phone #: \_\_\_\_\_

11. Who should we contact in case of an emergency?

Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

**I hereby certify that the information provided on this form is complete and accurate to the best of my knowledge.**

Print Name: \_\_\_\_\_ Authorized Signature: \_\_\_\_\_  
(Parent's Signature if under 18 years of age)

Team Name: \_\_\_\_\_ Date: \_\_\_\_\_