

Hampton Roads Adventure

Medical Form for Competitors, Support, Volunteers

Personal Information	Event: _____
Team Name: _____	Team Number: _____
Name: _____	DOB: _____
Address: _____	Sex: _____
Phone Number: _____	
Emergency Contact: _____	
Phone: _____	
Relationship: _____	

Medical Information
Do you have any physical disabilities that might limit your participation in the event? If so, please explain: _____ _____ _____
Are you on any special medications or dietary restrictions? If so, please explain: _____ _____ _____
Do you have allergies or allergic reactions to any medications? If so, please explain: _____ _____ _____
Medical Insurance Company: _____ Contract # _____ Group# _____

Due to the rugged and remote settings of Adventure Racing activities, access to hospital and medical Facilities may be limited. By signing this form, you are giving consent for medical treatment to HRAdventure staff and medical personnel in an emergency situation.

Signature of participant

Date