

**Individual Medical Form**



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

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

Home address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M F

Are you currently taking any medications? yes - no  
If so, please specify the types and the amounts you take: \_\_\_\_\_

Are you allergic to any medications? yes - no  
If yes, please specify: \_\_\_\_\_

Please list any allergies you have ( food, hay fever, dust...) and if you are currently being treated for them:  
\_\_\_\_\_  
\_\_\_\_\_

Have you been treated for any serious illnesses within the last three years? If yes, please describe:  
\_\_\_\_\_  
\_\_\_\_\_

Have you recently experienced or been diagnosed with any of the following? (circle those which 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 (glandular fever)
hypothyroid	hyperthyroid	tuberculosis
hepatitis ( which type? )		

Have you had any surgeries or surgical procedures within the last three years? If yes, please describe:  
\_\_\_\_\_  
\_\_\_\_\_

What is your blood type? \_\_\_\_\_

Do you wear eye glasses or contact lenses? \_\_\_\_\_

Is there anything else pertaining to your health that we should know about ( ie chance of being pregnant)? \_\_\_\_\_  
\_\_\_\_\_

Name of your current insurance: \_\_\_\_\_

Name, address and phone number of your doctor: \_\_\_\_\_

Name, address and phone number of the person we contact in case of emergency?  
\_\_\_\_\_  
\_\_\_\_\_

I certify that I am physically fit, have sufficiently trained for participation in the 24hours of southern **traverse**, and have not been advised otherwise by a qualified medical person. I also certify that all the information given above is correct.

Signature:

Date: