Medical Information Form
2015 Triathlon Season

Medical Information

Personal Physician

Name: _____

Address: _____

City: _____ **State, Zip:** _____

Phone _____ **Cell:** _____

Emergency Contact

Name: _____

Relationship: _____

Phone: _____

Cell: _____

Medications

Please list any medications taken on a regular basis (prescription and non-prescription)

MEDICATION	DOSE	FREQUENCY	REASON

Allergies

Are you allergic to any medications? NO _____ YES _____ If YES, please explain:

Allergic To: _____ Reaction: _____

Past and Current Medical History

Please list any current illness, recent injuries (within 12 months), recent surgeries (within 12 months) or past medical problems. If (NONE), please write NONE. Are there any special medical needs or information the Staff should be aware of?

_____

_____

_____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I, the undersigned parent or legal guardian of the child indicated above, a minor, do hereby authorize RockSteady Junior Triathlon Club personnel to obtain medical treatment or supervision deemed necessary for my child. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required. It is understood every effort shall be made to contact the undersigned prior to rendering treatment, but treatment will not be withheld if the undersigned cannot be reached.

Parent Signature: _____ Date: _____