MEDICAL INFORMATION SHEET

BLOOD GROUP

NAME:	COUNTRY:

PRESENT MEDICAL CONDITIONS:

PAST INJURIES

MEDICATION PRESENTLY USED:

Medication	Diagnosis

ALLERGIES:

ARE YOU CURRENTLY RECEIVING TREATMENT OR HAVE YOU EVER BEEN TREATED FOR:

Diabetes	YES	NO
Epilepsy	YES	NO
Asthma	YES	NO
Hypertension	YES	NO
Cardio Vascular Conditions	YES	NO
Blood Disorders	YES	NO
Head Injury	YES	NO

IF YES PLEASE SUPPLY DETAILS:

PLEASE NOTE: Withholding any relevant medical information will be ground for disqualification from the event.

SIGNATURE: ……………………………….