



2008 NorCal AIDS Challenge Medical Information Form

Complete this form and bring it to Registration Day on
Wednesday, May 14th, 4-7pm at CARES in Sacramento

Personal Information

| | | | |
|-------------------------------------|-----------------------------|--------------------------------------|-----------------------|
| Last Name | First Name & M.I | Date of Birth (mm/dd/yyyy) | Gender |
| Street Address | | City / State / Zip | |
| Home Ph# | Work Ph# | Cell Ph# | |
| Insurance Provider | Provider Ph# | Group No. | Subscriber No. |
| Primary Care Physician (PCP) | | PCP Phone # | |
| Emergency Contact | Relationship | Emergency Contact Phone | |

Medical History

Have you ever been diagnosed with any of the following?

| YES | NO | | YES | NO | | YES | NO | |
|-------|-------|---------------------------------|-------|-------|-----------------------------|-------|-------|--|
| _____ | _____ | Cardiac Disease | _____ | _____ | Seizures/Epilepsy | _____ | _____ | Thyroid Disease |
| _____ | _____ | Chest Pain | _____ | _____ | Arthritis | _____ | _____ | Gastro-Intestinal Problems |
| _____ | _____ | Shortness of Breath | _____ | _____ | Orthopedic Injury | _____ | _____ | Vision/Hearing Problems |
| _____ | _____ | Dehydration/ Heat Exhaustion | _____ | _____ | Diabetes | _____ | _____ | HIV Disease |
| _____ | _____ | High Blood Press. | _____ | _____ | Kidney Disease | _____ | _____ | Depression/Anxiety |
| _____ | _____ | Respiratory/ Lung Disease | _____ | _____ | Surgery in last 6 months | _____ | _____ | Cancer/Transplant Immunosuppression |

If you checked "YES" to any of the above, please provide further details. Also, if you have a medical problem not listed above, please provide additional information below, as well as any medication or food allergies:

Do you take medication regularly? If yes, please list all medications and dosages. Include over-the-counter medicines and/or nutritional supplements. **Please identify medications that will require refrigeration during the ride.**

I understand I am solely responsible for my health and safety, and I Acknowledge that I am physically capable of participating in and completing this Event. I understand that I must provide proof of insurance in order to participate, and agree that I will provide accurate proof of health insurance in effect during participation. I understand that my health information will be protected and that access to my health information and this medical form will be restricted to the NorCal AIDS Challenge. Information will not be released to any party without my permission.

PRINTED NAME

SIGNATURE

DATE SIGNED