St. Jude Rides Medical History Form

The following questionnaire is requested in the unlikely event you require emergent medical care while participating in any of the St. Jude Runs. The information you provide may help health care providers assist you under such circumstances. Please answer the following as accurately as possible.

Name: _____

Address: _____

Age: _____ Sex: M or F Date of Birth: _____

Medical Insurance Carrier: _____

Emergency Contacts: Name: _____ Home Phone #: _____

Relation: _____ Work Phone #: _____

Medical Data: Doctor: _____ Phone #: _____

What medications are you presently taking or may you be taking during the event (include prescription medications, over-the-counter medications, dietary supplements and herbal remedies)?

_____ _____ _____

_____ _____ _____

Known food, drug or environmental allergies:

_____ _____ _____

_____ _____ _____

Have you been treated or are you presently being treated for any of the following conditions. Please check all that apply and provide a detailed explanation for any checked responses in the area following.

Hypertension		Epilepsy		Lung Disease		Thyroid Disease	
Diabetes		Seizure Disorder		Hypotension		Liver Disease	
Heart Attack		Brain Tumor		Rheumatic Fever		Anxiety	
Renal Disease		Cancer		Heart Failure		Stroke	
Fainting		Psychiatric Disease		Myocarditis		Anemia	
Loss of Consciousness		Blood or Bleeding Disorder		Circulatory Disorder		Nervous System Disorder	
Gastrointestinal Disease		Other Endocrine Disease		Head, Eye, Ear, Nose, Throat Disorder		Other	

Special Conditions/Remarks:

_____

_____

_____

I affirm that the above information is correct to the best of my knowledge.

_____ _____

Signature Date

ANY INFORMATION PROVIDED WILL BE KEPT COMPLETELY CONFIDENTIAL