Lakeland Regional Health®

2020 FITCHURCH CHALLENGE
Medical Information Form

Full Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ E-mail: _____

EMERGENCY MEDICAL INFORMATION

Date of Birth: _____

1. List allergies, if any: (i.e. insect bites, drugs, food, etc. *NOTE*: counteractive medication should be carried at all times.)
   Circle one: NONE YES… _____
   _____
2. List any medications currently taken:
   Circle one: NONE YES… _____
   _____
3. List any current medical conditions: (i.e. asthma, diabetes, epilepsy, heart conditions, etc.)
   Circle one: NONE YES… _____
   _____
4. List any other condition that may affect your ability to participate: (i.e. history of cardiac conditions in family, etc.)
   Circle one: NONE YES… _____
   _____

Emergency Contact: _____ Daytime Phone: _____

Relationship to Participant: _____ Evening Phone: _____