

CONTESTANT MEDICAL FORM

CONTESTANT NAME _____

CONTESTANT NUMBER _____

LIST ANY ALLERGIES _____

LIST ANY MEDICATION YOU ARE CURRENTLY TAKING:

OTHER MEDICAL INFORMATION WE SHOULD KNOW:

NAME AND PHONE NUMBER OF PERSON TO CONTACT IN THE EVENT OF AN EMERGENCY:

UPON COMPLETION, I HEREBY RELEASE THIS MEDICAL INFORMATION FOR MEDICAL TREATMENT PURPOSES ONLY.

SIGNATURE

DATE

FORM MUST BE COMPLETED AND/OR SIGNED