

# Enterprise Association - Competitor Medical Form



**Voluntary medical information, for your safety, in the event of an accident or emergency and retained only for the duration of the event.**

## Please complete all sections in Block Capitals

**Name of Participant:** .....

Address .....

with .....

postcode: .....

Date of Birth: ..... Age: .....

Home Phone: .....

Mobile: .....

**Name of Emergency Contact:** .....

Relationship to above: .....

Contact number during event: .....

## Please list any medical conditions and any specific action to be taken if an episode of condition occurs:

.....  
.....  
.....

## Any other special needs or requirements that the race organisers should be aware of:

.....  
.....  
.....

### Medical Consent:

I give permission to the organisers to administer any relevant treatment or medication to the above named participant when or if necessary.

In an emergency situation I authorise the organisers to take me to hospital and give my full permission for any treatment required to be carried out in accordance with the hospital's diagnosis.

Signed (Participant): .....

Print Name: ..... Date: .....