



CYCLEBETES MEDICAL FORM



All participants must complete this Medical Form in order to participate in the event. Please hand in this form with your registration form.

Date_____

Team Name_____

Participant Name_____

Date of birth(dd/mm/yy)_____

Emergency Contact_____ Phone Number_____

Please note any health problems or other factors that may effect the participant in such event.

Are you subject to? (Please check the following)

Asthma() Fainting() Seizures() Nose Bleeds() High Blood
Pressure() Headaches() Dizziness() Sprains() Dislocations()

Severe Allergies (please list):
