FOR RIDER AND MEDICAL (EMT)

Name_______________________________________
Address_____________________________________
City _______________State ______ZIP__________
Home Phone (____)__________________________
Cell Phone (____)____________________________
Religious preference__________________________

BLOOD TYPE______________________________

Insurance Information

Name______________________________________
Address_____________________________________
City _______________State ______ZIP__________
Phone (____)________________________________
Date of Birth ___/___/____ Male ____ Female_____
Date this medical form was completed ___/___ /____
Companies Policy #_________Phone(____)______
Medicare #_________________________________
Physicians Phone(____)______________________

In Case of Emergency Please Notify

Primary Contact______________________________
Address_____________________________________
City _______________State ______ZIP__________
Phone (____)________________________________

Keep this card with you at all times.

TO BE RETAINED BY LEGACY RUN STAFF

Name______________________________________
Address____________________________________
City _______________State ______ZIP__________
Home Phone (____)__________________________
Cell Phone (____)____________________________

BLOOD TYPE______________________________

In Case of Emergency Please Notify (please list two)

Primary Contact_____________________________
Address____________________________________
City _______________State ______ZIP__________
Home Phone (____)__________________________
Cell Phone (____)____________________________

Secondary Contact___________________________
Address____________________________________
City _______________State ______ZIP__________
Phone (____)________________________________
Cell Phone (____)____________________________

Turn in this portion at Legacy Run check in.

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Please indicate any information you feel we should know.

Medical Conditions:

Allergies:

Medications:

Additional Information :

Turn in this portion at Legacy Run check in.

FOR RIDER AND MEDICAL (EMT)

I am taking the following medications:
(including over the counter and herbal products)

Drug Name	Strength/Dosage	How Often	Reason/Condition For the Drug

I have the following medical conditions/allergies:

Medical Conditions	Allergies (penicillin, sulfa, etc.)	Reactions to Allergies

Keep this card with you at all times.