

PENNSYLVANIA SENIOR GAMES

MEDICAL INFORMATION

THIS FORM MUST BE COMPLETED BY ALL PARTICIPANTS

PLEASE COMPLETE THIS FORM WITH YOUR MOST RECENT MEDICAL INFORMATION. THIS FORM MUST BE KEPT ATTACHED TO THE ENTRY FORM AND RECEIVED BY THE KEYSTONE STATE GAMES OFFICE BY JULY 2, 2010. **NO ONE WILL BE ALLOWED TO COMPETE WITHOUT THE COMPLETED MEDICAL FORM.** PLEASE PRINT OR TYPE ALL INFORMATION.

NAME _____ AGE _____

(AS OF 12/31/10)

ADDRESS _____ GENDER Female Male

PHONE/CELL _____ EMERGENCY CONTACT NAME _____

E-MAIL _____ EMERGENCY CONTACT PHONE _____

WILL EMERGENCY CONTACT BE AT THE COMPETITION? Yes No

PLEASE CHECK ANY KNOWN MEDICAL CONDITIONS:

Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bladder/Bowel Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Indigestion	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Discomfort When Exercising	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pains	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leg Pain On Walking	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Back Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty in Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty in Seeing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Allergies (List Below)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Passing Out Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No

CURRENT MEDICATIONS _____

LIST DRUG ALLERGIES _____

ARE YOU ALLERGIC TO BEE STINGS? _____

DATE OF MOST RECENT MEDICAL EXAMINATION _____

DOCTOR'S NAME _____ PHONE _____

I ATTEST THAT THE ABOVE INFORMATION IS CORRECT

PARTICIPANT'S SIGNATURE _____ DATE _____