CYCLIST MEDICAL INFORMATION FORM

Name of Cyclist: ____

Parents Contact Details: ____

MEDICAL DATA

First or Nickname:	Birth Date:
Nationality	Language:
Family Doctor Contact Details	Medicine Allergies (e.g.) Penicillin:
Medical History/Specify Medical Problems (e.g. Epilepsy,Diabetes,Hemophillia):	Surgical History/Operations:

Previous Serious Injuries:	Previous Serious Injuries:
Current Medication (Name and Dosage)	Family Medical History (e.g. Asthma)
Weight	Blood Group:
Religious Aspects concerning medical treatment (e.g. Blood Transfusion/Jehovah Witness):	Any other relevant medical information/requests that might influence medical decisions in an emergency.
Person Responsible for Payment/Principal Member of Medical Scheme	

Driver License-No:	Cellular phone:
Home Telephone:	Work Telephone:

Relative/Friend to contact in case of emergency (Name and Telephone Numbers):
Postal Address:

MEDICAL SCHEME INFORMATION

(Leave blank if not applicable) (Glue copy of both sides of Medical Aid Card here)

MEDICAL AID CARD COPY OF FRONT SIDE	MEDICAL AID CARD COPY OF BACK SIDE

(Name) ……………….............……… **(Signature)** ……………………………..……

(Date) ……………………………….