

# IDT at Plymouth Rock - Mandatory Medical Form

Athletes will not receive Official Bib# and timing chip at Registration unless this form is completed.  
Please complete and either return via (1) e-mail to chris @fastforwardrace.com; (2) fax to 781-749-2005; (3)  
US MAIL to Fast Forward Race Mgmt, PO BOX 573, Hingham, MA 02043

FIRST NAME:

LAST NAME:

DATE OF BIRTH (MM/DD/YR):

HOME ADDRESS:

CITY: STATE ZIPCODE

WHERE ARE YOU STAYING  
LOCALLY?

EMERGENCY CONTACT  
NAME:

EMERGENCY CONTACT  
PHONE #:

ARE YOU TAKING ANY MEDICATIONS (PLEASE LIST):

DO YOU HAVE ANY ALLERGIES (PLEASE LIST):

ARE YOU ALLERGIC TO BEE  
STINGS:

PLEASE LIST ANY PAST SURGICAL HISTORY:

MEDICAL HISTORY (CHECK ONE BOX ON EACH QUESTION)

YES

NO

- HEART DISEASE
- DIABETES
- HYPERTENSION
- THYROID
- STROKE
- ASTHMA
- LUNG DISEASE
- SEIZURES
- PEPTIC ULCERS
- CURRENTLY PREGNANT
- OTHER (PLEASE LIST)

PLYMOUTH ROCK TRIATHLON CONSENT TO TREAT/MEDICAL RELEASE FORM

I, \_\_\_\_\_, age, \_\_\_\_\_, while participating in the Plymouth Rock Triathlon, hereby consent to be treated by the Plymouth Rock Triathlon Staff, Physician(s), Nurse (s), EMT(s) or any other medical doctor recommended by the Plymouth Rock Triathlon Physician or Staff.

I expressly authorize the Plymouth Rock Triathlon Staff and such hospital and /or medical doctor or medical facility, which might render medical treatment to me during this period, to release my medical condition and activity capabilities to the Plymouth Rock Triathlon Staff.

I also give the Plymouth Rock Triathlon Staff permission to provide other medical facilities with medical and insurance information that would expedite my care should I need emergency or other patient services.

Date:

Athlete Signature: