

St. Jude Run Medical History Form

The following questionnaire is requested in the unlikely event you require emergent medical care while participating in any of the St. Jude Runs. The information you provide may help health care providers assist you under such circumstances. Please answer the following as accurately as possible.

Name: _____

Address: _____

Age: _____ Sex: M or F Date of Birth: _____

Medical Insurance Carrier: _____

Emergency Contacts: Name: _____ Home Phone #: _____

Relation: _____ Work #: _____

Medical Data: Doctor: _____ Phone #: _____

What medications are you presently taking or may you be taking during the run (include prescription medications, over-the-counter medications, dietary supplements and herbal remedies).

Known food, drug or environmental allergies:

Have you been treated or are you presently being treated for any of the following conditions. Please check all that apply and provide a detailed explanation for any checked responses in the area following.

Special Conditions/Remarks:

I affirm that the above information is correct to the best of my knowledge.

Signature Date

ANY INFORMATION PROVIDED WILL BE KEPT COMPLETELY CONFIDENTIAL