SKF Goa River Marathon

MEDICAL PARTNERS

Name: ________________________________ **Mobile** ______________

Age: ____ **Sex:** M / F **Blood Group:** ____

Have you done a medical check up to take part in event? YES / NO

Any Allergies: YES / NO **Please Specify if Yes:** ____________________

Have you had in the past or do you currently have any of the following: (check any that apply)

- ☐ Anemia
- ☐ Asthma
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Fainting Spells
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Neurological Disorders
- ☐ Lung Disease

If you answered yes to any of the above, please provide details you feel are relevant.

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Emergency Contact

Emergency Contact Number: ________________________________

Emergency Contact Person name: ________________________________

Relation: ________________________________

Address: ________________________________