MEDICAL QUESTIONNAIRE

Full Name ____
Address ____
Contact No. ____
Team name _________________________________

Emergency contact details
If you are involved in an accident who should we contact and how

Name _________________________________
Telephone _________________________________

Health and Safety Issues
Do you have any history of the following:

Heart problems	YES/NO
Fainting spells	YES/NO
Pain in chest when exercising	YES/NO
High blood pressure	YES/NO
Low blood pressure	YES/NO
Breathing difficulties/asthma	YES/NO
Joint problems	YES/NO
Epilepsy	YES/NO
Back complaints	YES/NO
Are you on any sort of medication?	YES/NO
Diabetes	YES/NO
Any other significant illnesses or recent operations	YES/NO
Are you over 40	YES/NO
Do you smoke	YES/NO
Do you drink more than the recommend levels for your sex?	YES/NO
Do you have any disabilities	YES/NO

If you have answered yes to any of the above please give details:
____
____
____

The above information is correct at the time of writing. Should any of the information change I will inform a member of Tribal Events staff, at the earliest opportunity.

Signature _____________________ Date __________