



# CONFIDENTIAL MEDICAL QUESTIONNAIRE



**ATTENTION:** Medical Doctor,

The Dryland Traverse is a multi-day adventure trail run, covering approximately 69km. Please assist us in our efforts to provide the runner with the best possible medical support at the event, by completing this medical questionnaire. All this information is treated in the strictest confidence.

## PERSONAL DETAILS

Surname: ..... First Name: .....

Address: .....

.....

ID/Passport nr: ..... Age: .....

Emergency Contact name during race: .....

Emergency Contact Tel (1): ..... Emergency Contact Tel (2): .....

## CURRENT PHYSICAL CONDITION

Resting Heart Rate: ..... Blood Pressure: ..... Blood Group: .....

## MEDICAL HISTORY

Does the patient have any surgical history?  Y  N If so, please elaborate: .....

Does the patient suffer from a permanent condition (e.g. Asthma, Epilepsy, etc.)?  Y  N If so, please elaborate: .....

Does the patient suffer from any allergies (e.g. insect bites, penicillin)?  Y  N If so, please elaborate: .....

Is the Patient currently on any medication?  Y  N If so, please list: .....

Is there anything else in the patient's medical history that you feel the medical team at Dryland Traverse should be aware of?

.....

## SPECIAL DIETARY REQUIREMENTS

Please provide information here: .....

## MEDICAL AID

In order to provide the best possible medical care in the event of an accident or emergency, we require the following information:

Medical Aid Name: ..... Medical Aid nr: .....

Medical Aid Scheme: ..... Main Member: .....

OR Travel Health Insurance Provider: ..... Health Insurance Policy nr: .....

Health Insurance Contact Tel: .....

Doctor's Name: ..... Contact Tel: .....

Date of appointment: .....

Signed (Doctor): ..... Signed (Runner): .....

PLEASE EMAIL OR FAX THIS FORM TO THE DRYLAND TRAVERSE MEDICAL TEAM:

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