



Lexus Great British Bike Ride 2010

Rider Form – Medical Information 1 of 2

Please complete this Form ASAP and hand in at Registration at Lands End.

Riders must agree to inform GBBR Ltd of any medical or other condition that might affect their ability to take part in the Lexus GBBR.

Please complete your contact details below in full.

1. RIDER DETAILS (Please use BLOCK CAPITALS)

Name: _____

Rider Number: _____

Date of Birth: _____

Contact mobile number: _____

2. MEDICAL INFORMATION

Do you suffer from, or have you ever suffered from:

- | | | |
|--|------------------------------|-----------------------------|
| Heart and/or blood pressure problems..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Diabetes | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Migraines | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Back problems | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Allergies | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Psychiatric or mental illness | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Asthma/bronchitis and/or shortness of breath | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Epilepsy and/or fainting episodes | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Severe head injury | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Fractures, tendon, ligament/cartilage damage | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Physical or other disability | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Psychiatric or mental illness | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Additional details (please include further information if you have answered 'Yes' to any of the above questions – add second sheet if necessary):



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3. MEDICATION

Please list below any medication you are taking:

4. OTHER QUESTIONS

Have you attended hospital for any investigations/treatment in the last two years?

Do you smoke? Yes No

Are you suffering from, or a carrier of, any infectious diseases? Yes No

Are you registered as disabled? Yes No

Are you pregnant? Yes No

Do you suffer from any other conditions that are not stated above? Yes No

Additional details (Please include further information if you have answered 'Yes' to any of the above questions):

5. EMERGENCY CONTACT INFORMATION

Name: _____

Relationship: _____

Contact Phone Number(s): _____

6. SIGNED _____ DATE _____

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