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**Please do not give your race number to another runner without informing us.
To do so could lead to serious repercussions in the event of
an emergency and could lead to your disqualification by the race referee.**

Please complete this form in BLOCK CAPITALS before participating in the event.

PERSONAL

Surname: _____ **First Name:** _____

Address: _____

_____ **Postcode:** _____

Date of Birth: _____ **Age:** _____ **Gender:** M / F (circle)

MEDICAL CONDITIONS*

Medical History: ☐ Respiratory ☐ Asthma ☐ Diabetes
☐ High Blood Pressure ☐ Cardiac
☐ Stroke ☐ Seizures ☐ Other (provide details below)

Known Allergies: _____

_____

Regular Medication: _____

_____

Other Details: _____

_____

NEXT OF KIN

Surname: _____ **First Name:** _____

Address: _____

_____ **Postcode:** _____ **Telephone:** _____

Is this person present at this event? ☐ Yes ☐ No

*** If you have any medical conditions, allergies or take regular medication, please draw a visible BLACK CROSS with a marker pen on the front of the race number.**

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REVERSE PRINT

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Important! Please check spelling, punctuation, size, number sequence, layout and confirm your approval via email in writing.
No liability will be accepted for errors not notified.