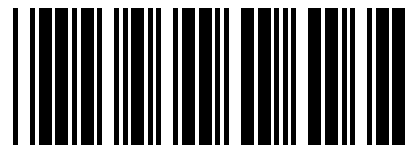




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Colour : dark red

Number of pages to
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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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