



Statement and Release Regarding Medical Condition

To be completed by participant and returned to ALYN Hospital (contact info below):

Confidential Assessment of Physical Fitness to participate in the ALYN Hospital "Wheels of Love" Bike Ride 20__.

To be filled out by Participant:

Name _____

ID# (SS/Passport) _____ Date of Birth _____ (dd/mm/yy)

1) List present or past conditions or injuries that may affect your ability to take part in the Ride (such as hypertension, cardiovascular diseases, neurological disorders, diabetes, arthritis, etc.), or if none, state "none".

2) I take the following medications routinely (including alternative medications):

3) Have you received a tetanus inoculation within the past five years? Yes No

If not when was your last inoculation? Year _____

4) Other health information that the organizers should be aware of:

ENCLOSED IS MY MEDICAL CLEARANCE FORM SIGNED BY A PHYSICIAN THAT WILL ALLOW ME TO PARTICIPATE IN THE ALYN HOSPITAL WHEELS OF LOVE BIKE RIDE 20__. I HEREBY AUTHORIZE THE ORGANIZERS OF THE RIDE TO RELEASE MY MEDICAL INFORMATION TO THE MEDICAL SUPERVISOR OF THE RIDE AND TO ANY THIRD PARTY GIVING TREATMENT TO ME, AT THE SOLE AND ABSOLUTE DISCRETION OF THE ORGANIZERS.

Signature of Participant _____ Date _____

Overseas participants are reminded to take out travel insurance. Should medical treatment be required beyond the WOL medical team, participants must personally cover the cost of treatment. A receipt will then be issued and used to apply for reimbursement from the participant's own health insurance policy.

To be completed by Physician:

For Riders:

Riders will be cycling anywhere from 50km/32mi to 140km/90mi a day for a five day period (except for one-day riders) depending on the route they picked.

I hereby certify that the above information is correct to the best of my knowledge and the rider (name) _____ is medically capable to participate in a bike ride requiring intense physical activity as indicated above.

For Volunteers: I hereby certify that the above information is correct to the best of my knowledge and the volunteer (name) _____ is medically capable to work a 10 hour, physically active day.

Additional comments: _____

Signature of Physician _____ Date _____ Medical Stamp _____