

FOR RIDER AND MEDICAL (EMT)

Name _____
Address _____
City _____ State _____ ZIP _____
Home Phone (____) _____
Cell Phone (____) _____
Religious preference _____

BLOOD TYPE _____

+ EMERGENCY MEDICAL RECORD +
 American Legion Riders
www.legion.org/riders
(317) 630-1265
ATTN: POLICE & MEDICAL PERSONNEL

Insurance Information

Name _____
Address _____
City _____ State _____ ZIP _____
Phone (____) _____
Date of Birth ___/___/___ Male ___ Female ___
Date this medical form was completed ___/___/___
Companies Policy # _____ Phone(____) _____
Medicare # _____
Physicians Phone(____) _____

In Case of Emergency Please Notify

Primary Contact _____
Address _____
City _____ State _____ ZIP _____
Phone (____) _____

Keep this card with you at all times.



TO BE RETAINED BY LEGACY RUN STAFF

Name _____
Address _____
City _____ State _____ ZIP _____
Home Phone (____) _____
Cell Phone (____) _____

BLOOD TYPE _____

In Case of Emergency Please Notify (please list two)

Primary Contact _____
Address _____
City _____ State _____ ZIP _____
Home Phone (____) _____
Cell Phone (____) _____

Secondary Contact _____
Address _____
City _____ State _____ ZIP _____
Phone (____) _____
Cell Phone (____) _____

Turn in this portion at Legacy Run check in.

TO BE RETAINED BY LEGACY RUN STAFF

Please indicate any information you feel we should know.

Medical Conditions: _____

Allergies: _____

Medications: _____

Additional Information : _____

Turn in this portion at Legacy Run check in.



FOR RIDER AND MEDICAL (EMT)

I am taking the following medications:
(including over the counter and herbal products)

Drug Name	Strength/Dosage	How Often	Reason/Condition For the Drug

I have the following medical conditions/allergies:

Medical Conditions	Allergies (penicillin, sulfa, etc.)	Reactions to Allergies

Keep this card with you at all times.