



**MEDICAL FORM**  
Autumn Escape Bike Trek

Trekker Name: \_\_\_\_\_

If you have any of the following conditions or are currently experiencing any of them, please circle the number and give details at the end of this section.

1. Any problem with vision or hearing - require glasses or hearing aid, contacts (hard or soft).
2. Dizzy spells, fainting, convulsions, persistent headaches.
3. Shortness of breath, or asthma on exertion.
4. Chest pains on exertion or deep breathing.
5. Palpitation of the heart, irregular heart beat, heart murmur, or poor circulation.
6. Jaundice or hepatitis
7. Chronic pain in neck, back, shoulders, arms or legs.
8. Reaction to extremes of temperature, frostbite, impaired circulation.
9. Hypoglycemia.
10. Episodes of depression, anxiety, hysteria, nervousness.
11. History of diabetes, thyroid trouble, bleeding problems.
12. Currently on medication? If so, what?

\_\_\_\_\_

13. Allergic to any of the following? Food \_\_\_\_\_ Drugs \_\_\_\_\_ Other \_\_\_\_\_

\_\_\_\_\_

14. What is your current level of physical activity?    Excellent    Good    Poor

If you circled any of the above items, please list details below according to number. Be specific (include dates, names of medications, history of condition, etc.) Use additional paper if necessary.  
Notes:

\_\_\_\_\_

**MEDICAL INSURANCE COVERAGE**

Each person must be covered by his/her own sickness and accident insurance. For our insurance records, answers to the following questions are required and to be supplied in detail.

Is applicant covered by hospitalization and medical care policy?    Yes    No

If yes, indicate name and address of insurance company issuing such policy:

\_\_\_\_\_

Indicate policy or certificate number: \_\_\_\_\_

Name on policy: \_\_\_\_\_

Return this form to:

**Susan Binnall**  
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