Wisconsin Association of Fairs Contestant Medical Form

***Please bring with you to registration at convention completed.**

Contestant Name ______________________________ **D.O.B.** ______________

Fair ______________________________ **Contestant #** ______________

Emergency Contact Information:

Name: ______________________________ Relationship: ______________

Primary Phone# ______________________________ Secondary Phone# ______________

Contact Person attending the Convention: **(i.e. Fair Board Member, Fairest Chair/Coordinator)**

Name ______________________________ Cell #______________

Relationship ______________________________

Medical Contact:

Physician ______________________________

Clinic ______________________________ Phone # ______________

MEDICAL HISTORY Please check all that apply:

ALLERGIES: Medical Alert Information

_____Foods
_____Medications
_____Bee Stings
_____Other ______________
_____Other ______________

Is treatment needed for allergy **Y** **N**

Do you carry an Epi pen? **Y** **N**

Description of Allergy:

____

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Please provide any medical concerns we should be aware, i.e., diabetic, asthma, seizures, concussions, etc.

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AUTHORIZATION FOR EMERGENCY REFERRAL AND MEDICAL TREATMENT/TRANSPORT

I, ______________________________, authorize the Wisconsin Association of Fairs personnel to contact our medical contact and authorize treatment. If the situation is recognized by the attending personnel as emergent, I give the Wisconsin Association of Fairs permission to arrange transportation for myself to the nearest medical facility. I agree to assume all cost involved, including possible ambulance fees.

______________________________ ______________

Fairest Contestant Signature Date