FOR RIDER AND MEDICAL (EMT)

Name _____
Address _____
City _____State _____ZIP _____
Cell Phone _____
Religious preference _____

BLOOD TYPE _____

EMERGENCY MEDICAL RECORD

American Legion Riders

ATTN: POLICE & MEDICAL PERSONNEL

Insurance Information

Name _____
Address _____
City _____State _____ZIP _____
Cell Phone _____
Date of Birth _____ Gender_____
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 _____
Cell Phone _____

BLOOD TYPE _____

In Case of Emergency Please Notify (please list two)

Primary Contact _____
Address _____
City _____State _____ZIP _____
Phone _____

Secondary Contact _____
Address _____
City _____State _____ZIP _____
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: _____

Are you a first responder? If yes, please specify: ☐

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.