



# Health check sheet

This information will be used if you have an accident.

◆ Please complete the form

①	How many hours did you sleep last night? Was it enough sleep for you?	About _____ hours <input type="checkbox"/> Yes <input type="checkbox"/> No
②	Did you drink alcohol last night?	<input type="checkbox"/> No <input type="checkbox"/> Yes → (What kind? How much?)
③	Are you currently receiving any medical treatment or medical follow-up?	<input type="checkbox"/> No <input type="checkbox"/> Yes → (For what?)
④	Are you taking any medications?	<input type="checkbox"/> No <input type="checkbox"/> Yes → (For what?)
⑤	Are you feeling good today?	<input type="checkbox"/> Yes <input type="checkbox"/> No → (Why?)
⑥	How is your blood pressure?	<input type="checkbox"/> Normal <input type="checkbox"/> High <input type="checkbox"/> Low
⑦	Have you had any illness including fever in the last month?	<input type="checkbox"/> No <input type="checkbox"/> Yes → (What?)
⑧	If ⑦ yes, How long? Have you recovered?	From _____ / _____ / _____ to _____ / _____ / _____ <input type="checkbox"/> Yes <input type="checkbox"/> Not yet
⑨	Have you been hospitalized in the past year?	<input type="checkbox"/> No <input type="checkbox"/> Yes → (Reason)
⑩	If ⑨ yes, How long were you in the hospital? Did you have any surgery?	From _____ / _____ / _____ to _____ / _____ / _____ <input type="checkbox"/> No <input type="checkbox"/> Yes → (What part?)
⑪	Have you ever given up or withdrawn from an OWS race?	<input type="checkbox"/> No <input type="checkbox"/> Yes → (Why?)

Date :        /        /	The name of the race:
<b>【No.】</b>	<b>【Name】</b>
<b>【Signature】</b>	
<b>【Who should be contacted if you have an accident?】</b>	
Name	Phone number
Relation	