

EX2 Adventures, LLC

MEDICAL QUESTIONNAIRE

**Greenhorn Adventure Race Held at Rocky Gap State Park in Flintstone, MD on April 26, 2008
(the "Race")**

NAME ("Racer"): _____
(FIRST) (LAST)

ADDRESS: _____ GENDER: M F AGE: _____
CITY _____ STATE _____ ZIP _____ E-MAIL: _____
(H) PHONE _____ (W) PHONE _____
NAME OF PHYSICIAN _____ PHONE _____
EMERGENCY CONTACT _____ PHONE _____

RACER UNDERSTANDS, ACKNOWLEDGES AND AGREES THAT:

The purpose of this questionnaire is to gather relevant medical information for disclosure to a health care provider if Racer suffers an injury during the Race, and EX2 Adventures, LLC ("EX2") determines, in its sole discretion, that Racer requires immediate medical attention. In the event that EX2 makes such a determination, Racer hereby authorizes EX2 to disclose the medical and other information on this questionnaire to a health care provider, including without limitation, a doctor, nurse, physician's assistant, emergency medical technician, policeman, fireman or other provider.

EX2 is not making a determination of a Racer's fitness; rather, the Racer represents and verifies to EX2 that he or she is physically fit and ready to participate in this demanding competition.

Racer understands and acknowledges that his or her failure to disclose relevant information may result in harm to Racer and/or others during this competition. Racer represents and warrants that he or she has provided all relevant information to EX2 pertaining to Racer's medical, mental and physical condition and fitness for participation in the race. Racer agrees to notify EX2 of any changes in his or her mental, physical or medical condition prior to the race.

EX2 will use commercially reasonable efforts to maintain the secrecy of the information provided on this Questionnaire. Upon conclusion of the Race, this Questionnaire will be destroyed.

Please circle either **yes** or **no** for the following questions.

Do you have currently or have a history of:

- 1) **Yes No** Diabetes or Blood Sugar Problem
- 2) **Yes No** Asthma or Respiratory Problems
- 3) **Yes No** Epilepsy or Seizures
- 4) **Yes No** Heart Disease
- 5) **Yes No** High Blood Pressure
- 6) **Yes No** Do you smoke
- 7) **Yes No** Are you pregnant
- 8) **Yes No** Musculoskeletal injuries, breaks, sprains or dislocations
- 9) **Yes No** Orthopedic conditions that are aggravated by physical activity
- 10) **Yes No** Mental or Neurological Problems

- 11) **Yes No** Bleeding Disorders
- 12) **Yes No** A recent injury, illness or infectious disease
- 13) **Yes No** Chronic or Recurring illness/condition
- 14) **Yes No** Recently hospitalized
- 15) **Yes No** Recent surgery
- 16) **Yes No** Frequent headaches
- 17) **Yes No** Ever had a head injury
- 18) **Yes No** Ever been knocked unconscious
- 19) **Yes No** Wear glasses, contacts or protective eye wear
- 20) **Yes No** Ever passed out during or after exercise
- 21) **Yes No** Ever been dizzy during or after exercise
- 22) **Yes No** Ever had a chest pain during or after exercise

Please explain any "yes" answer _____

Allergies & Treatments: medication, food, insect stings, poison ivy, plants, anaphylaxis _____

List any additional medications you are required to take on a regular basis (antibiotics, anti-seizure, insulin, blood pressure regulator), or emergency basis (epi-pens, gluco-pens). _____

By signing this document, I agree to the terms set forth in this document and acknowledge that I have provided this medical information accurately, completely and truthfully.

Signed: _____ Date: _____