



Rider Medical Form

Rider, Guardian, and Physician, please complete this form and return to The Agape Project at least one week prior to the Rider participating in an event with The Agape Project.

The completed form should be returned to
The Agape Project
2010 Westridge Drive
Shelby Township, MI 48316

Rider Information

Name: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Phone: () - _____
Email: _____

Guardian Information

Name: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Phone: () - _____
Email: _____

Physician Information

Name: _____
Office Address: _____
City: _____ State: _____ Zip: _____
Office Phone: () - _____

Physician Initials/Date _____ / _____ /2024
Guardian Initials/Date _____ / _____ /2024



Rider Medical Form

1. List the primary diagnoses/injury that resulted in the Rider's disability.

2. How long has the Rider had this disability? _____

3. Describe the Rider's level of disability.

a) Wheelchair level ___ manual ___ electric – mode of operation _____

b) Assistive device ___ cane ___ crutches ___ walker (standard/rolling/4-wheel)

c) Transfers ___ min assist ___ moderate assist ___ max assist x 1/2

d) Other pertinent info

4. The Agape Project team may assist the Rider into and out of the running chair?

___ Yes ___ No

If "No" then the guardian will provide help if assistance is required.

Physician Initials/Date _____ / _____ /2024
Guardian Initials/Date _____ / _____ /2024



Rider Medical Form

5. Does the Rider have a history of seizures? ___ Yes ___ No

If, YES, how often?

Can the Rider (or people around the Rider) tell when the Rider is about to have a seizure?

How long do the seizures last?

Is there anything that can be done to help the Rider through the seizure?

6. Is the Rider continent?

___ Yes ___ No If NO, does the Rider require any special accommodation during the race? _____

7. Does the Rider require any nutrition (food, beverage, medication) feeding during the race?

___ Yes ___ No

If YES, explain (include frequency): _____

Does the Rider require help with this nutrition?

___ Yes ___ No

If YES, explain: _____

Physician Initials/Date _____ / _____ /2024
Guardian Initials/Date _____ / _____ /2024



Rider Medical Form

8. Are there any other medical or physical issues that we should be aware of? Please explain:

9. Does the rider have any allergies that we should be aware of? Please list and explain if we can help prevent exposure and what action to take in the event of a reaction:

10. Does the Rider communicate?

Talks: ___ Yes ___ No

Listens: ___ Yes ___ No

Performs Motions: ___ Yes ___ No

Comprehends Motions: ___ Yes ___ No

MEDICAL STATEMENT

I hereby acknowledge that I have examined the above participant on _____ and verify that he/she is able to participate in an event by riding in a running chair while being fully assisted by the staff & volunteers of The Agape Project

Physician Signature _____

Physician Printed Name _____

Date _____

Physician Initials/Date _____ / _____ /2024
Guardian Initials/Date _____ / _____ /2024



Rider Medical Form

PRIVACY STATEMENT

I hereby acknowledge that The Agape Project will keep all information provided within this form confidential within the community of people running, riding, and supporting The Agape Project events. All information will be available (as needed) to The Agape Project board of directors, and only information relevant to keeping the Rider safe and comfortable during the event will be available to runners and support staff.

Rider Signature _____

Rider Printed Name _____

_____ Date _____

Guardian Signature _____

Guardian Printed Name _____

_____ Date _____

Physician Initials/Date _____ / _____ /2024
Guardian Initials/Date _____ / _____ /2024