

SPECIAL OPERATIONS ADVENTURE RACE

The Special Operations Adventure Race (SOAR) for 2010 will be held in the Blue Ridge Mountains and centered in the resort community of Highlands, NC. The United States Adventure Racing Association sanctions the race. It will require 5 to 7 hours for the sprint race and 10 to 12 hours for the elite race. This will include orienteering, trail running, mountain biking, a water event, and rappelling. The race is unsupported. Racers must supply their own harness, **rappelling helmet**, compass, bicycle helmet, bicycle and nourishment. Only 120 racers will be allowed to register.

SOAR will benefit the Special Operations Warrior Foundation, www.specialops.org.

You must be able to use a topographic map to participate.

We intend to have 10 divisions and champions: Single entry Male, Single entry Female, Male Team, Female Team, Mixed Team and the same divisions for Masters (over 40 years of age).

When: Friday, June 11, 2010
Late Registrations, Check-In and Gear Check
Noon – 6:00 PM

Spaghetti Dinner - \$7
5 – 6:45 PM

Mandatory Pre-race meeting (Absence is Disqualifying):
7:00 PM

Where: Highlands Civic Center
US-64 and Laurel Street
Highlands, NC

Who: Adventurous types looking for a challenge in a beautiful environment and for a noble cause

Elite Race start: Saturday, June 12, 2010, 7:00 AM

Sprint Race start: Saturday, June 12, 2010, 8:00 AM

After Race Food, Beer and Wine 5:00 PM at Highlands Conference Center, US-64 and Popular Street. Free to Racers, \$7.00 all others.

Awards as soon as determined at Highlands Conference Center

2010 SOAR MEDICAL INFORMATION FORM FOR COMPETITORS/SUPPORT/VOLUNTEERS

All Team Members, Support Personnel and Volunteers must read, complete and sign this form. Please list all information requested. **Please print.**

SECTION I – PERSONAL INFORMATION

TEAM NAME: _____ TEAM NUMBER: _____ DOB: _____ SEX: M F

NAME: _____ HT: _____ WT _____
LAST FIRST M.I.

ADDRESS: _____
STREET

EMERGENCY CONTACT

CITY, STATE or PROVINCE, COUNTRY__

NAME _____

PHONE _____

PHONE NUMBER: _____

RELATIONSHIP: _____

SECTION II – MEDICAL HISTORY

Are you currently taking any type of prescription or over-the-counter medications? YES ___ NO ___ If YES please list names and dosages:

Are you allergic to any foods or medications? YES ___ NO ___ If YES, please list: _____

What is your Blood Type / RH Factor? _____

Do you have a current or past history of any of the following?

Allergies (food, dust, etc.)	Yes__ No__	Dizziness/Fainting	Yes__ No__	Joint Problems	Yes__ No__
Allergies (insect bite)	Yes__ No__	Epilepsy	Yes__ No__	Kidney Problems	Yes__ No__
Arthritis	Yes__ No__	Eye Problems	Yes__ No__	Major Surgery	Yes__ No__
Asthma	Yes__ No__	Cold Injuries	Yes__ No__	Malaria	Yes__ No__
Back Problems	Yes__ No__	Headaches	Yes__ No__	Mononucleosis	Yes__ No__
Blood in Stool	Yes__ No__	Hearing Problems	Yes__ No__	Nausea / Vomiting	Yes__ No__
Blood in Urine	Yes__ No__	Heart Problems	Yes__ No__	Numbness in Limbs	Yes__ No__
Blurred Vision	Yes__ No__	Hepatitis (what type)	Yes__ No__	Respiratory Problems	Yes__ No__
Bronchitis	Yes__ No__	Hernia	Yes__ No__	Stomach Problems	Yes__ No__
Cancer	Yes__ No__	High/Low Blood Pressure	Yes__ No__	Tuberculosis	Yes__ No__
Diabetes	Yes__ No__	Hyper/Hypothyroidism	Yes__ No__	Other Not Listed	Yes__ No__

If YES to any of the above, please explain: _____

Do you wear eyeglasses/contact lenses?
YES ___ NO ___
If YES, do you have spare glasses/contacts
or a copy of your prescription?
YES ___ NO ___

Females -
Are you, or could you be pregnant?
YES ___ NO ___
If YES, when is your due date?

When was your last menstrual period?

SECTION III – HEALTH CARE PROVIDER AND INSURANCE INFORMATION

PHYSICIAN'S NAME: _____ PHONE NUMBER: _____
ADDRESS: _____

INSURANCE CARRIER: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

This form is for the purpose of having your medical and contact information available if you must be transported and/or hospitalized by an agency outside of SOAR. All medical care provided by SOAR medical personnel is provided to you with no direct fee.

I, _____, verify that the above information is true and correct, to the best of my knowledge. I understand that SOAR and Emergency Medical Services will uphold patient confidentiality and safeguard my medical and personal information. I understand that I have the right to refuse medical treatment, except where the law allows for Implied Consent Treatment. I understand that SOAR provides this medical care to me with no direct fee. I understand that Emergency Medical personnel will make medical treatment and transport decisions that are based solely on what is in my best medical interest.

Signed: _____ Date: _____

OFFICE USE ONLY BELOW THIS LINE

SOAR MEDICAL REVIEW AND NOTES

EVENT: 2010 Special Operations Adventure Race, Highlands, NC DATE: June 12, 2010

REVIEWED BY: _____ DATE: _____