MS. AMERICA® PAGEANT

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Medical Information (complete Attachment B - Medical Information Form).

Current Medical Condition. Other than as described in the attached Medical Information Form (Attachment B), I do not presently suffer from any illness, disease or disability that will prohibit, restrict, or impair my ability to fulfill my obligations under this Agreement or to fulfill my *Term of Service* as an At-Large Titleholder or *Term of Service* as a National Titleholder. At the present time I am (__) receiving treatment or medication for the condition described in Attachment B or (__) not receiving treatment or medication for this condition **(check as applicable)**. I (__) do (__) do not expect to be taking medication or to be receiving treatment for this condition during the competition or, if selected as MS AMERICA® "YEAR" or MAI "YEAR" or MI "YEAR", during my *Term of Service*.

Current Medication. Other than as specified in the attached Medical Information Form (Attachment B), I am not presently being treated or medicated for any medical condition or disability, and I do not have any reason to believe that I will be treated or medicated for any medical condition or disability during the competition or, if selected as MS. AMERICA® "YEAR" or MAI "YEAR" or MI "YEAR", during my *Term of Service*.

Attachment B
Medical Information Form

Page 1

AT-LARGE TITLEHOLDER NAME: _____

DATE OF BIRTH: _____

HOME ADDRESS: _____

WHO SHOULD BE CALLED IN CASE OF AN EMERGENCY?

NAME: _____

ADDRESS: _____

PHONE: HOME: _____ **OFFICE:** _____

MEDICAL INSURANCE COMPANY/HMO NAME: _____

EMPLOYER OR COMPANY NAME (IF GROUP PLAN): _____

POLICY NUMBER: _____

NAME OF SUBSCRIBER:_____

Physician_____

Phone#_____

Attachment B
Medical Information Form

YOUR BLOOD TYPE: _____

MEDICATIONS TO WHICH YOU HAVE AN ALLERGIC REACTION: _____

_____

ANY PHYSICAL PROBLEMS THAT COULD CAUSE YOU DISCOMFORT: _____

_____

DENTAL INSURANCE COMPANY NAME: _____

Address, City, State, Zip Code: _____

_____

EMPLOYER OR COMPANY NAME (IF GROUP PLAN): _____

POLICY NUMBER: _____

NAME OF SUBSCRIBER:_____

PLEASE ATTACH A COPY OF YOUR INSURANCE CARD(S) – INCLUDING MEDICAL, PRESCRIPTION AND DENTAL

I certify the policy(s) named above is now in force and will be maintained through _____. I understand that contestants are responsible for all medical/dental expenses incurred during the time in which they participate in Ms. America® Pageant_____ competition activities and that neither the Ms. America® Pageant nor its medical insurance plan will be responsible for any such expenses. I certify that the above information is accurate and true.