

MEDICAL INFORMATION FORM

(Good for Two (2) Years)

MUST BE COMPLETED BY ALL NOT EXCEEDING TECH SPEED OF 165 MPH

Participant Name: _____

Circle One: **Driver** **Navigator**

In the event of an accident the following information is important. Please complete the following:

HEALTH HISTORY

YES	NO	YES	NO	YES	NO
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Asthma
 Tuberculosis
 Kidney Disease
 Psychiatric Disorder
 Cardiovascular Disease
 Permanent defect from illness, disease
 Nervous Stomach
 Muscular Disease
 Rheumatic Fever
 Any other nervous disorder
 Suffering from any other disease
 Head or Spinal Injuries
 Extensive confinement
 Seizures, fits, convulsions or fainting
 Diabetes
 Gastrointestinal ulcer

If the answer to any of the above is YES, explain: _____

PARTICIPANT: Sex: _____ Height: _____ Weight: _____ Date of Birth: _____

Blood Type: _____ Drug Sensitivities: _____

	<u>NORMAL</u>	<u>ABNORMAL</u>		<u>NORMAL</u>	<u>ABNORMAL</u>
Vision	_____	_____	Heart Condition	_____	_____
Hearing	_____	_____	Lungs & Chest	_____	_____
Extremities	_____	_____	General Systemic	_____	_____
Neurological	_____	_____			
Comments:	_____				

Drug Allergies: _____ Medical Alerts: _____

Current Medications: _____ Other: _____

Name of Personal Physician (Please Type or Print) Phone Number

In Case of Emergency, Please Contact: _____
Name (Type or Print Legibly) Relationship Phone Number

I **do** ___ give SSCC permission to release my medical information/physical form to emergency personnel.
I **do not** ___ give SSCC permission to release my medical information/physical form to emergency personnel.
I attest that I have current Medical Insurance Coverage.

Participant Signature Date
Valid From _____ Thru _____