Silver State Classic Challenge, Inc., a Non-Profit Corporation

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/Co-Driver

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

HEALTH HISTORY

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

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

_____

PARTICIPANT: Sex: _____Height:_____Weight:_____ Date of Birth: _____

Blood Type: _____ Drug Sensitivities: _____

	NORMAL	ABNORMAL		NORMAL	ABNORMAL
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_____

Car # _____