

BIENNIAL PHYSICAL CERTIFICATION FORM

(Good for 2 Years)

MUST BE COMPLETED BY A DOCTOR FOR ALL THAT TECH OVER 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

Table with 6 columns: YES, NO, YES, NO, YES, NO. Rows include Asthma, Tuberculosis, Kidney Disease, Syphilis, Gonorrhea, Diabetes, Nervous Stomach, Muscular Disease, Rheumatic Fever, Psychiatric Disorder, Cardiovascular Disease, Gastrointestinal ulcer, Head or Spinal Injuries, Extensive confinement, Seizures, fits, convulsions or fainting, Any other nervous disorder, Suffering from any other disease, Permanent defect from illness, disease Injury.

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

PHYSICAL EXAMINATION

PHYSICIAN: The above named individual has applied to participate in the Nevada Open Road Challenge and/or the Silver State Classic Challenge. The event may require him/her to drive a motor vehicle at very high speeds on a closed public highway for a distance of ninety (90) miles. For this person's safety and the safety of other participants, we need to know if there is any reason why this individual should not enter this event based upon any limiting physical or psychological condition.

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

Blood Type: _____ Blood Pressure: _____ Drug Sensitivities: _____

Table with 4 columns: Vision, Hearing, Extremities, Neurological (Reflexes, coordination etc.), Heart Condition, Lungs & Chest, General Systemic. Rows are labeled with NORMAL and ABNORMAL.

Comments: _____

Drug Allergies: _____ Medical Alerts: _____

Current Medications: _____ Other: _____

I have examined the above individual and found no evidence of physical impairment or chronic health disorder that should preclude him/her from driving a motor vehicle in the above described event.

Signature box containing fields for Name of Physician (Please Type or Print), Physician's Signature, Date, Physician's License Number, License State, Address, City, Zip, Phone.

To Be Completed By The Participant:

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 _____

Office Use Only: Car # _____

Valid From _____ Thru _____