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

MEDICAL INFORMATION FORM (DRIVER)

(Good till Driver makes changes)

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

Participant Name: _____

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 the event of an 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

THIS FORM MUST BE FILLED OUT BY DRIVER

Car # _____