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

YESNO()() Asthma()() Tuberculosis()() Tuberculosis()() Kidney Disease()() Psychiatric Disorder()() Cardiovascular Disease()() Permanent defect from illness, disease	() () Mus () () Rhe () () Any	vous Stomach scular Disease umatic Fever other nervous disorder 'ering from any other disease	YES () () () () () () ()	NO () 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:				
	-	Weight:]		Birth:
NORMAL Vision Hearing Extremities Neurological Comments:	<u>ABNORMAL</u>	Heart C Lungs o	Condition & Chest	NORMAL ABNORMAL
Drug Allergies: Medical Alerts:				
Current Medications: Other:				
Name of Personal Physician (Pleas		Phone N	lumber	
In the event of an emergency,	Please Contact	: Name (Type or Print Legib	oly)	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 # _____