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

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 OR Co-Driver (CIRCLE ONE)

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
( )	( ) Syphilis	( )	( ) Psychiatric Disorder	( )	( ) Any other nervous disorder
( )	( ) Gonorrhea	( )	( ) Cardiovascular Disease	( )	( ) Suffering from any other disease
( )	( ) Diabetes	( )	( ) Gastrointestinal ulcer	( )	( ) 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: _____

	NORMAL	ABNORMAL		NORMAL	ABNORMAL
Vision	_____	_____	Heart Condition	_____	_____
Hearing	_____	_____	Lungs & Chest	_____	_____
Extremities	_____	_____	General Systemic	_____	_____
Neurological (Reflexes, coordination etc.)	_____	_____			

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.

_____ _____ _____

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 _____