

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 |
| () | () | () | () | () | () |
| () | () | () | () | () | () |
| () | () | () | () | () | () |
| () | () | () | () | () | () |
| () | () | () | () | () | () |
| () | () | () | () | () | () |
| () | () | () | () | () | () |
| () | () | () | () | () | () |

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

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

Blood Type: _____ Drug Sensitivities: _____

	<u>NORMAL</u>	<u>ABNORMAL</u>		<u>NORMAL</u>	<u>ABNORMAL</u>
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 # _____