

Medical Form



Name:		<input type="checkbox"/> Driver	<input type="checkbox"/> Crew / Co-Driver
		<input type="checkbox"/> General	<input type="checkbox"/> Junior (parent or guardian must sign)
Driver's information →	Class:	Vehicle #	Birthdate: MM/DD/YY
Medical Information			
List all allergies:			
List medications you take daily (include name and dosage.):			
Chronic Illnesses (such as diabetes):	Injury history:	Major surgery history:	
Heart problems (include pacemaker):	CT Scan / MRI's in past 5 years:	Hospitalization in past 5 years: Explain:	
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you chew tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you wear dentures? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you wear glasses or contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you wear hearing aids? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Emergency Contact: (please list a person NOT attending the race.)			
Name:			
Day time phone:		Evening Phone:	
Emergency Contact – Person to contact AT the race			
Name:			
Day time phone:		Evening Phone:	
Authorized signature:			Date: