

Pacific Raceways
Driver Medical Condition Form
Please Complete in Full

DRIVERS MEDICAL INFORMATION

DRIVERS NAME: _____ DATE: _____

SOCIAL SECURITY NUMBER: _____ AGE: _____ DATE OF BIRTH ___/___/___

BLOOD TYPE: _____ DATE OF LAST TETANUS: _____

PRESCRIPTION MEDICATIONS: _____

SPECIAL MEDICAL CONDITIONS: _____

INSURANCE INFORMATION

CARRIER: _____ ID NUMBER: _____

GROUP: _____ SUBSCRIBER: _____

EMERGENCY CONTACT

NAME: _____ REALATION: _____

PHONE: _____ ALTERNATE PHONE: _____

OTHER INFORMATION:

Please circle the following that applies to you:

CONTACTS DENTURES ASTHMATIC DIABETIC EPILEPTIC
HERMOPHLIAC HEARING IMPAIRED PREGNANT HYPERTENSION

PLEASE LIST ANY ALLERGIES: _____

CONFIDENTIALITY

The above information is to be released to on site track medical services, emergency personal in the event of injury or incident involving the above listed driver/operator while at Pacific Raceways. Information may be released to receiving hospital in case of transport to aid in medical treatment.