

2010 Viper Days Med Stats

BLOOD TYPE - _____

Name _____ Date of Birth _____ Sex _____

Street Address _____

City - _____ State _____ Zip Code _____ Phone Number _____

Health Insurance Carrier _____

Policy # if required _____ Ins. Co. Phone # _____

Personal Physician _____ Phone number _____

Allergies: _____

Allergies to Food: _____

Current Medication: (incl. dosage) _____

Previous Injuries: _____

Past Surgeries: _____

Medical History – Including Present Conditions _____

Date of last Tetanus Shot: _____ **Religion (Optional)** _____

Emergency Contact Information (Is this person with you at the track?) Y N

Name: _____ Relationship: _____

Telephone Number (H): _____ (W): _____

Alternate Contact Name: _____ Relationship: _____

Telephone Number (H): _____ (W): _____

“YES” Please check if the following are applicable to you!

___ Hepatitis A ___ Hepatitis B ___ Hepatitis C ___ Hepatitis D

___ **Aids**

___ **Organ donor**

___ **Vision – Eye Glasses** ___ **Contacts**

___ **Dentures/Oral Fixtures** ___ **Upper** ___ **Lower**

___ Frequent or severe headaches

___ Dizziness or fainting spells

___ Diabetes – Insulin ___ Pills ___ Diet Controlled ___

___ Heart trouble ___ Epilepsy ___ Stomach Problems

___ Blood pressure HIGH - ___ LOW - ___

___ Motion sickness requiring drugs

___ Admission to hospital in last year

___ Physical disability

Comments: _____

Applicant’s Signature: _____ Date: _____