CALIFORNIA ROADRACE ASSOCIATION
2021

MEDICAL INFORMATION & RELEASE FORM

PARTICIPANT INFORMATION

NAME: _____ INSURANCE PROVIDER: _____

ADDRESS: _____ POLICY #: _____

CITY: _____ STATE: _____ GROUP/PLAN NAME: _____

EMAIL: _____ INSURANCE PHONE #: _____

DOB: _____ SEX: _____

AGE: _____

EMERGENCY CONTACT INFORMATION

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____

PHONE #: _____

RELATIONSHIP: _____

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____

PHONE #: _____

RELATIONSHIP: _____

MEDICAL INFORMATION

NAME OF DR.: _____ MEDICATIONS:

ADDRESS: _____

CITY: _____ STATE: _____ MEDICINAL

PHONE #: _____ ALLERGIES: _____

CHECK ALL THAT APPLY:

Heart Disease ☐ Stroke ☐

Diabetes ☐ Glasses ☐

Seizures ☐ Contacts ☐

PRE-EXISTING CONDITIONS:

_____

_____

The undersigned, on behalf of him/herself or minor, if applicable, hereby authorizes and consents to any X-Ray, examination, anesthetic, medical or surgical diagnostic or treatment and hospital care, to be rendered under the general or special supervision and upon the advice of a physician and surgeon licensed under the provisions of the California Medicine Practices Act, and does hereby authorize and consent to any X-Ray, examination, anesthetic, dental or surgical diagnostic or treatment and hospital care to be rendered by a dengist under the provisions of the California Dental Practices Act.

PARTICIPANT SIGNATURE: _____

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____