

# 20%\$ NGAR MEDICAL INFORMATION FORM

## FOR COMPETITORS/SUPPORT/VOLUNTEERS

All Team Members, Support Personnel and Volunteers must read, complete and sign this form. Please list all information requested. **Please print.**

### SECTION I – PERSONAL INFORMATION

TEAM NAME: \_\_\_\_\_ Team Number: \_\_\_\_\_

DOB: \_\_\_\_\_ SEX: M \_\_\_ F \_\_\_

HT: \_\_\_\_\_ WT: \_\_\_\_\_

NAME: \_\_\_\_\_  
LAST FIRST M.I.

#### EMERGENCY CONTACT

ADDRESS: \_\_\_\_\_  
STREET

NAME: \_\_\_\_\_

\_\_\_\_\_  
CITY, STATE or PROVINCE, COUNTRY

PHONE: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

### SECTION II – MEDICAL HISTORY

Are you currently taking any type of prescription or over the counter medication?

YES \_\_\_ NO \_\_\_

If "YES", please list names and dosages.

\_\_\_\_\_

Are you allergic to any type of **medication**?

YES \_\_\_ NO \_\_\_

If "YES", please list. \_\_\_\_\_

\_\_\_\_\_

Do you currently have or have had a history of any of the following?

	YES	NO		YES	NO		YES	NO
Allergies (food, dust, etc.)			Dizzy/Fainting			Joint Problems		
Allergies (insect bite)			Epilepsy			Kidney Problems		
Arthritis			Eye Problems			Major Surgery (within 3 yrs)		
Asthma			Cold Injuries			Malaria		
Back Problems			Headaches			Mononucleosis		
Blood in Stool			Hearing Problems			Nausea / Vomiting		
Blood in Urine			Heart Problems			Numbness in Limbs		
Blurred Vision			Hepatitis (what type)			Respiratory Problems		
Bronchitis			Hernia			Stomach Problems		
Cancer			High/Low Blood Pressure			Tuberculosis		
Diabetes			Hyper/Hypothyroidism			Other not Listed		

If "YES" to any of the above, please explain. \_\_\_\_\_

\_\_\_\_\_

What is your Blood Type / RH Factor? \_\_\_\_\_

Do you wear eyeglasses/contact lenses?

YES \_\_\_ NO \_\_\_

If "YES", do you have spare glasses/contacts or a copy of your prescription?

YES \_\_\_ NO \_\_\_

Females -

Are you, or could you be pregnant? YES \_\_\_ NO \_\_\_

If "YES", when is your "due date"? \_\_\_\_\_

When was your last menstrual period? \_\_\_\_\_

**SECTION III – HEALTH CARE PROVIDER AND INSURANCE INFORMATION**

NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

INSURANCE CARRIER: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

Please attach a copy of your insurance card to the back of this form.

(This is for the purpose of having this information available if you must be transported and/or hospitalized by an agency outside of Raceday Event Management, Inc. )

I, \_\_\_\_\_, verify that the above information is true and correct, to the best of my knowledge. I understand that Raceday Event Management will uphold patient confidentiality and safeguard my medical and personal information. I understand that I have the right to refuse medical treatment, except where the law allows for Implied Consent Treatment. I understand that R.E.M. provides this medical care to me with no direct fee. I understand that R.E.M medical personnel will make medical treatment and transport decisions that are based solely on what is in my best medical interest.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**OFFICE USE ONLY BELOW THIS LINE**

**RACEDAY MEDICAL REVIEW AND NOTES**

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EVENT: \_\_\_\_\_ DATES: \_\_\_\_\_

REVIEWED BY: \_\_\_\_\_ DATE: \_\_\_\_\_