

2010 Oregon Motorcycle Road Racing Association

Medical Information and Treatment Authorization Form

- Original
- Duplicate
- Change of Info.

A copy of this form must be on your person at all times.

Riders-front left inside of your jacket. Volunteers/Other - Clearly visible external pocket area.

PERSONAL MEDICAL INSURANCE IS REQUIRED TO RACE WITH OMORRA AT PORTLAND INTERNATIONAL RACEWAY

PART I

<input type="checkbox"/> Rider	<input type="checkbox"/> Volunteer	<input type="checkbox"/> Other _____ (pit crew, photo, etc.)
--------------------------------	------------------------------------	--

PART II

Applicant Name					
Address			Home Phone:		Cell Phone:
City	State	Country	Zip/Postal Code		
Age	Date of Birth				

Person(s) to be notified <i>locally</i> (if at all possible) if you are injured:		
Name:	Relationship to you:	
Address	City	State
Contact # for this person:		

Primary Care Physician			Insurance Company		
Address			Address		
City	State	Zip	City	State	Zip
Phone			Phone		Policy No.
Blood type (if known)	In case of emergency, I authorize the use of blood products: <input type="checkbox"/> YES <input type="checkbox"/> NO				
Date of last Tetanus Shot	Contact Lenses <input type="checkbox"/>	Dentures <input type="checkbox"/>	Diabetic <input type="checkbox"/>	Epileptic <input type="checkbox"/>	Heart problems <input type="checkbox"/>
Previous Spine or Head Injuries: NONE <input type="checkbox"/> YES <input type="checkbox"/> Describe:					
No known medication allergies:			Known Medication allergies		
Type of Reaction:					
List any surgeries, serious or chronic illnesses:					

PART III

A. Consent and authorization for medical, hospital and/or dental services

The undersigned, on behalf of himself or minor, if applicable, hereby authorizes and consents to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care, to be rendered under the general or special supervision and upon advice of a physician and surgeon licensed in the State of Oregon, Washington, or California, where applicable, and does hereby authorize and consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care, to be rendered by a licensed dentist in the State of Oregon, Washington, or California, where applicable.

I hereby confirm consent, and agree to the foregoing.

Applicant _____ Date _____

Parent or Guardian _____ Date _____

Witness _____ Date _____

Signature of parent, guardian or person having legal custody if applicant is under 18 yrs of age

ALL SIGNATURES MUST BE WITNESSED

ONE COPY IN LEATHERS FOR RACERS OR EASILY ACCESSIBLE IF A VOLUNTEER, ONE COPY FOR ASIT