Original ___ Duplicate ___ Change of info ___

# OREGON MOTORCYCLE ROAD RACING ASSOCIATION
## 2012 Medical Information and Treatment Authorization Form

### 1. PERSONAL INFORMATION:

| | |
|---|---|
| Name: | Phone: ( ) |
| Address: | Email: |
| City, State, Zip: | Date of Birth: |

### 2. EMERGENCY CONTACT (person able to make medical decisions for you if you are seriously injured):

| | |
|---|---|
| Name: | Phone: ( ) |
| Address: | Email: |
| City, State, Zip: | Relationship to you: |

### 3. PHYSICIAN INFORMATION:

| | |
|---|---|
| Primary Care Physician: | Phone: ( ) |
| Address: | |
| City, State, Zip: | |

### 4. INSURANCE INFORMATION (current medical insurance* required to race with OMRRA):

| | |
|---|---|
| Insurance Company: | Phone: ( ) |
| Address: | Policy number: |
| City, State, Zip: | |

* Check your policy carefully to make sure injuries sustained while motorcycle racing are covered. Don't gamble with your financial future or that of your family.

### 5. HEALTH INFORMATION:

| | |
|---|---|
| Blood type: | List recent surgeries, illnesses, head injury, or other medical conditions: |
| Last tetanus shot date: | |
| Medication allergies: Yes No | In emergency, I authorize the use of blood products: Yes No |
| If yes, list allergies: | Contacts: ___ Dentures: ___ Diabetic: ___ Epileptic: ___ Heart Condition: ___ |
| Organ Donor? Yes No | Do you have an Advance Health Care Directive? Yes No |

### 6. 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 also 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.

_____ _____
**Signature of Applicant** Date

_____ _____
**Signature of Witness** Date

_____ _____
**Signature of Parent or Guardian** Date
(required if applicant is under 18 years of age)

**Carry one copy of this form in your leathers (if racer), or in your pocket (if volunteer), at all times while at PIR. One copy to ASIT.**