

MEDICAL INFORMATION FORM



TODAY'S DATE:

* A new copy of this form must be filled out for each race season. This form valid only for the calendar year in which it was completed.

1. PERSONAL INFORMATION:

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

2. EMERGENCY CONTACT (person – local recommended - able to make medical decisions for you):

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

3. INSURANCE INFORMATION (current medical insurance required to race with OMRRA & WMRRA):

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

**Carry one copy of this form in your leathers at all times while at the racetrack.
Additionally, OMRRA requires a copy on file with Registration.**