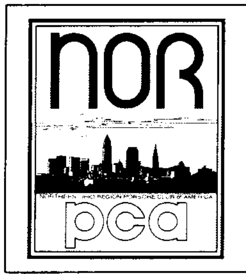

CAR #

Please do not fill in
For office use only

NORTHERN OHIO REGION PCA
DRIVER EDUCATION
MEDICAL FORM

Complete this form and submit it with your application.

(Please print or type a separate form for each driver. IF YOU WILL BE DRIVING MORE THAN ONE CAR AT THIS EVENT, PLEASE COMPLETE A FORM FOR EACH CAR.)

Driver Name ______________________________

Address: ______________________________

City: ____________________ State: __________ Zip: ____________

Telephone: (Home) __________ (Work) __________ (Cell) __________

Car model: __________ Color __________ Year __________

Please list medical training or ratings: ______________________________

DRIVER MEDICAL INFORMATION:

Age: ____________________

Current Medications: ____________________ Drug Allergies: ____________________

List any special conditions: ____________________ Blood Type: ____________________

Personal physician: __________ Address: __________ Phone: __________

CIRCLE YES OR NO

CONTACTS	**Y**	**N**	DENTURES	**Y**	**N**	ASTHMATIC	**Y**	**N**
DIABETIC	**Y**	**N**	EPILEPTIC	**Y**	**N**	HEMOPHILIAC	**Y**	**N**

IN EMERGENCY, NOTIFY:

Name: ____________________ Phone: ____________________

Address: ____________________ At Track? Yes __ No __

I verify that this information is correct, and provide permission to use this information only in the case of a medical emergency.

Signed ____________________ Date: ____________________

ALL EVENT PARTICIPANTS SHOULD HAVE THEIR NAME ON THEIR DRIVING HELMET.

THIS FORM MUST BE COMPLETED AND PRESENTED AS PART OF THE APPLICATION PACKET

NOTE: This information is kept confidential and is to be utilized only in the event of an emergency, and will be destroyed after the event.