NEAR NEW ENGLAND ANTIQUE RACERS

VOLUNTARY MEDICAL EMERGENCY CONTACT FORM

Date: _____

Type_____ Color_____ Number _____

Type_____ Color_____ Number _____

Last Name _____ First Name _____ MI: _____

Physical Address _____

Mailing Address _____

Home Phone: _____ Cell Phone_____

Email: _____

Date of Birth: _____Blood Type: _____Last Tetanus shot date: _____

Allergies: _____

Regular Medications: _____

Medical Problems: _____

(Please mention any condition such as Heart disease, high blood pressure, kidney disease, diabetes, etc.)

Please list all major surgeries in the past 5 years: _____

_____

Do you wear; Contact Lenses Glasses Dentures Other:_____ (Please circle all that apply)

Are you an organ donor? YES NO Specific Organs: _____

Do you have medical insurance? YES NO If yes, please complete the following:

Company Name: _____ Policy No: _____

Emergency Contact Last Name: _____ First Name: _____

Physical Address: _____ Relationship: _____

Telephone # of contact _____ Will he/she be at track? YES NO