

**MKM RACING - MEDICAL INFORMATION FORM  
HIGH ROLLER MILE SHOOTOUT**

**(each Driver/Rider/Alternate must complete a separate form, and also an Emergency Information form)**



Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

**HEALTH HISTORY**

- |                          |                          |                       |                          |                          |                        |                          |                          |  |
|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|------------------------|--------------------------|--------------------------|--|
| <b>Yes</b>               | <b>No</b>                |                       | <b>Yes</b>               | <b>No</b>                |                        | <b>Yes</b>               | <b>No</b>                |  |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma                | <input type="checkbox"/> | <input type="checkbox"/> | Nervous Stomach        | <input type="checkbox"/> | <input type="checkbox"/> | Head or Spinal Injuries                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis          | <input type="checkbox"/> | <input type="checkbox"/> | Muscular Disease       | <input type="checkbox"/> | <input type="checkbox"/> | Extensive confinement by Illness or Injury   |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney                | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever        | <input type="checkbox"/> | <input type="checkbox"/> | Seizures, fits, convulsions, or fainting     |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood-Borne Pathogens | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Disorder   | <input type="checkbox"/> | <input type="checkbox"/> | Any other nervous disorder                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes              | <input type="checkbox"/> | <input type="checkbox"/> | Cardiovascular Disease | <input type="checkbox"/> | <input type="checkbox"/> | Any other diseases                           |
|                          |                          |                       | <input type="checkbox"/> | <input type="checkbox"/> | Gastrointestinal Ulcer | <input type="checkbox"/> | <input type="checkbox"/> | Permanent defect from Illness/disease/injury |

If answer to any of the above is yes, explain: \_\_\_\_\_  
\_\_\_\_\_

Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Type: \_\_\_\_\_

Drug Sensitivities: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Medical Alerts: \_\_\_\_\_

Name of Personal Physician or Health Care Provider (MANDATORY): \_\_\_\_\_

Phone Number of Personal Physician or Health Care Provider (MANDATORY): \_\_\_\_\_

Insurance Carrier and Policy Number: \_\_\_\_\_

**Vision:** Right 20/\_\_\_\_ Left 20/\_\_\_\_ Both 20/\_\_\_\_ With/Without Corrective Lenses (circle one)

- |                 |                          |                          |
|-----------------|--------------------------|--------------------------|
|                 | Normal                   | Abnormal                 |
| Hearing         | <input type="checkbox"/> | <input type="checkbox"/> |
| Extremities     | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Condition | <input type="checkbox"/> | <input type="checkbox"/> |
| Lungs & Chest   | <input type="checkbox"/> | <input type="checkbox"/> |
| General System  | <input type="checkbox"/> | <input type="checkbox"/> |

If ABNORMAL, explain: \_\_\_\_\_

**I DO/DO NOT (circle one) give MKM Racing Promotions permission to release my medical information to emergency medical personnel.**

By signing this form below, you certify that the above is true and complete, and further certify there are no physical or mental limitations to your participation in any MKM Racing Promotions, LLC event.

Participant Signature \_\_\_\_\_ Date \_\_\_\_\_