

Southern California Timing Association

Medical Information

Entry No. _____

Name _____ Age _____

Address _____

City _____ State _____ ZIP _____

Support Crew at Event

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Insurance No _____ Yes _____ If yes, complete below

Carrier _____ ID No. _____

Group _____ Subscriber _____

Emergency Contact

Name _____ Relation: _____

Phone _____ 2nd Phone _____

Alternate Contact Name _____ Phone _____

Medical Information

Physician: _____ Phone _____

Date of: Last Tetanus shot _____ Last Exam _____

Prescription Medication Please list _____

Allergies to medications _____

Past surgical history: _____

Other Medical Issues: Check all that apply

Insulin Dependent Diabetic		Blood problems – anemia		Other special needs -List
Heart Disease		Blood problems - clotting difficulties		
High Blood Pressure		Musculoskeletal problems		
Respiratory Problems		Malignancy		
Previous head injuries		Seizure disorder		

Check one	No	Yes
Contact lens	<input type="checkbox"/>	<input type="checkbox"/>
Dentures	<input type="checkbox"/>	<input type="checkbox"/>
Asthmatic	<input type="checkbox"/>	<input type="checkbox"/>
Diabetic	<input type="checkbox"/>	<input type="checkbox"/>
Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>
Epileptic	<input type="checkbox"/>	<input type="checkbox"/>
Hemophiliac	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Impaired	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Allergies <small>If Yes, Please list</small>	<input type="checkbox"/>	<input type="checkbox"/>

Authorization for Emergency Care: In case of an emergency, wherein I am incapable of giving consent due to illness or injury, I authorize any qualified person to administer first aid and/or other necessary treatment. I further authorize any licensed surgeon to perform life-saving surgery, if the need for surgery is agreed upon by two (2) physician's judgment.

Signed _____ Date _____