



MKM RACING
MOJAVE MILE/ MOJAVE MAGNUM
MEDICAL INFORMATION FORM
 (each Driver or Rider must complete this form,
 and also an Emergency Information form)



Name: _____

Address: _____

Date of Birth: _____ Age: _____

HEALTH HISTORY: Do you have, or have you ever had, any of these:

- | | | | | | | | | |
|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|------------------------|--------------------------|--------------------------|----------------------------------------------|
| Yes | No | | Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Digestive disease | <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 probs. | <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 significant 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/Allergies: _____

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) or (Without) Corrective Lenses (check one)

Current conditions: Are there any current abnormalities in the following areas?

- Hearing Extremities Heart Condition Lungs & Chest General System Condition

If any are checked, provide details: _____

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

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

Participant Signature _____ Date _____