Original ___ Duplicate ___ Change of info ___

OREGON MOTORCYCLE ROAD RACING ASSOCIATION

2017 Volunteer Medical Information and Treatment Authorization Form

1. PERSONAL INFORMATION:

Name:	Phone: ( )
Address:	Email:
City, State, Zip:	Date of Birth:

2. EMERGENCY CONTACT (person – local recommended - able to make medical decisions for you):

Name:	Phone: ( )
Address:	Email:
City, State, Zip:	Relationship to you:

3. PHYSICIAN INFORMATION:

Primary Care Physician:	Phone: ( )
Address:	
City, State, Zip:	

4. HEALTH INFORMATION:

Blood type:	List recent surgeries, illnesses, head injury, or other medical conditions:
Last tetanus shot date:	
Medication allergies: Yes No	In emergency, I authorize the use of blood products: Yes No
If yes, list allergies:	Contacts: ___ Dentures: ___ Diabetic: ___ Epileptic: ___ Heart Condition: ___
Organ Donor? Yes No	Do you have an Advance Health Care Directive? Yes No

5. CONSENT AND AUTHORIZATION (for medical, hospital and/or dental services):

The undersigned, on behalf of himself, or minor if applicable, hereby authorizes and consents to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care, to be rendered under the general or special supervision and upon advice of a physician and surgeon licensed in the State of Oregon, Washington, or California where applicable, and does also hereby authorize and consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care, to be rendered by a licensed dentist in the State of Oregon, Washington, or California where applicable. I hereby confirm consent, and agree to the foregoing.

_____ _____

Signature of Applicant **Date**

_____ _____

Signature of Witness **Date**

_____ _____

Signature of Parent or Guardian **Date**
(required if applicant is under 18 years of age)

Carry one copy of this form in your pocket, at all times while at PIR. One copy to ASIT.