

# LUCAS OIL DRAG BOAT RACING SERIES

## MEDICAL INFORMATION FORM

**THIS FORM GOES TO THE MEDICAL AND RESCUE PERSONNEL AT EACH RACE**

Participants full name \_\_\_\_\_ Boat# \_\_\_\_\_ Class \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Birth Date \_\_\_\_\_

Spouse's name (or next of kin ) \_\_\_\_\_ Phone \_\_\_\_\_

Social Security # \_\_\_\_\_ Age \_\_\_\_\_ Wt: \_\_\_\_\_ Blood Type \_\_\_\_\_ contact Lenses \_\_\_\_\_

Medications presently using: (prescribed /otc meds) \_\_\_\_\_

\_\_\_\_\_

Medical Allergies \_\_\_\_\_

Past Medical History : (explain) \_\_\_\_\_

High Blood Pressure: yes/No Diabetes: yes/No Heart Disease: yes/No Asthmas: yes/No

Other: \_\_\_\_\_

DO YOU HAVE HOSPITALIZATION INSURANCE? YES \_\_\_\_\_ NO \_\_\_\_\_

(If the answer is yes, please complete the Insurance Affidavit below)

### INSURANCE AFFIDAVILT

COMPANY: \_\_\_\_\_

GROUP # \_\_\_\_\_ POLICY# \_\_\_\_\_

CONTACT PHONE \_\_\_\_\_

I, THE UNDERSIGNED, HEREBY CERTIFY THAT I HAVE IN EFFECT A HOSPITALIZATION POLICY OF LIMITS NOT LESS THAN TEN THOUSAND (\$10,000) DOLLARS. I FURTHER CERTIFY THAT I SHALL FIRST FILE ANY AND ALL CLAIMS FOR DAMAGES, PERSONAL INJURY AND/OR ACCIDENTS THROUGH MY INSURANCE CARRIER PRIOR TO RELYING ON ANY INSURANCE PROVIDED BY THE LUCAS OIL DRAG BOAT RACING SERIES.

MY BENEFICIARY IS: \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

PARTICIPANTS SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

WITNESS SIGNATURE \_\_\_\_\_ DTAE \_\_\_\_\_