

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 _____

