

# 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 \_\_\_\_\_ 2<sup>nd</sup> 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 \_\_\_\_\_