CVMA Medical Information and Treatment Release

Competition # ____________

Name (printed):____

Address: ____
Street City State Zip Code

Phone: _____________________ Date of Birth (mm/dd/yyyy): ________________

Emergency Contacts:

Primary Contact (printed):____

Address: ____
Street City State Zip Code

Phone: _____________________ Alternative Phone: _____________________

Secondary Contact (printed):____

Address: ____
Street City State Zip Code

Phone: _____________________ Alternative Phone: _____________________

Insurance Information:

Name of Provider: ______________________________ Policy #: _____________

Group/Plan Name: ________________________ Phone: __________________

Medical Information:

Name of Doctor (printed):____

Address: ____
(Include city and zip code)

Phone: _____________________ Alternative Phone: _____________________

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Please circle if you have had any of the following conditions:

Heart disease

High Blood Pressure

Diabetic Taking Insulin

Contact Lenses

Dentures

Seizures or Epilepsy

Head Injuries (if so, provide date) ______________________________________

List all medications regularly taken _____________________________________

Medicine allergies _____________________________________

The undersigned, on behalf of himself or minor, if applicable, hereby authorizes and consents to any X-Ray, examination, anesthetic, medical or surgical diagnostic or treatment and hospital care, to be rendered under the general or special supervision and upon the advice of a physician and surgeon licensed under the provisions of the California Medicine Practices Act, and does hereby authorize and consent to any X-Ray, examination, anesthetic, dental or surgical diagnostic or treatment and hospital care to be rendered by a dentist under the provisions of the California Dental Practices Act.

Name (signature and date) ____

Name (print) and Competition Number________________________________

Name (signature) of parent or legal guardian if applicable:

____

Chuckwalla Valley Motorcycle Association
P.O. Box 307, Desert Center, CA 92239
760.227.3100