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: _____

Chuckwalla Valley Motorcycle Association
P.O. Box 7107 La Quinta, CA 92248
760.360.2834

CVMA Medical Information and Treatment Release

Competition # _____

CHUCKWALLA VALLEY MOTORCYCLE ASSOCIATION

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 7107 La Quinta, CA 92248
760.360.2834