

# Driver's Education Medical Form

## Zone 2, Porsche Club of America

This form must be filled out for each event. If two drivers are registering, then both drivers must complete and sign the form. **PLEASE PRINT OR TYPE.**

Event: \_\_\_\_\_ Event Date: \_\_\_\_\_

### DRIVER #1:

Name: \_\_\_\_\_ Age: \_\_\_\_\_

In case of emergency notify: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ At track: \_\_\_\_\_

List Current Medications: \_\_\_\_\_ List Drug Allergies: \_\_\_\_\_

List any special medical conditions: \_\_\_\_\_ Blood Type: \_\_\_\_\_

Personal Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

#### Answer Yes or No:

- |                              |                             |                |                              |                             |             |
|------------------------------|-----------------------------|----------------|------------------------------|-----------------------------|-------------|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Contact Lenses | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Diabetic    |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Dentures       | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Hemophiliac |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Asthmatic      | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Epileptic   |

Driver #1 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### DRIVER #2:

Name: \_\_\_\_\_ Age: \_\_\_\_\_

In case of emergency notify: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ At track: \_\_\_\_\_

List Current Medications: \_\_\_\_\_ List Drug Allergies: \_\_\_\_\_

List any special medical conditions: \_\_\_\_\_ Blood Type: \_\_\_\_\_

Personal Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

#### Answer Yes or No:

- |                              |                             |                |                              |                             |             |
|------------------------------|-----------------------------|----------------|------------------------------|-----------------------------|-------------|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Contact Lenses | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Diabetic    |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Dentures       | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Hemophiliac |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Asthmatic      | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Epileptic   |

Driver #2 Signature: \_\_\_\_\_ Date: \_\_\_\_\_