NORTHEAST MOTORCYCLE ROAD RACING

Race Number

2024 Rider Medical Form

*REQUIRED BY ALL RIDERS TO BE FILLED OUT IN FULL (Please write N/A if not applicable)

Last: _____First: _____MI: _____

Date of Birth: _____ Cell #: _____

Mailing Address: _____

Email: _____

Allergies to medication: _____

Latex allergy: YES ☐ NO ☐

Prescription medication: _____

Blood thinners: YES ☐ NO ☐

Circle all that apply: Heart disease *High blood pressure* Kidney disease *Diabetes*

Cardiac events: _____

Pacemaker/Defibrillator: YES ☐ NO ☐

Surgeries in the past 5 years: _____

Check all that apply: Contacts ☐ *Glasses* ☐ Dentures ☐

Medical Insurance

Insurance Co._____ Policy #_____

Emergency Contact:

Full Name: _____

Cell # (_____) _____Relationship: _____