CIRCLE ONE:

CAR / MOTORCYCLE

Applicant's Medical History for The Texas Mile™
To be completed by Participant
▪ Phone: 281-303-1844
Fax: 281-605-1340 ▪ info@texasmile.net ▪

ASSIGNED CAR/BIKE #_____

Name:_____ Age:_____ Sex:_____ Date of Birth:_____

Address:_____ City:_____ State & Zip:_____

(H) Phone #: _____ Cell Phone #:_____

Your Personal Physician:_____ Phone #:_____

Address:_____ City:_____ State & Zip:_____

Have you been treated for, have you ever had, or have you now, any of the following: (Yes responses should be explained on the lines provided below or on an attached sheet)

Conditions	Yes	No	Conditions	Yes	No
Frequent or Severe headaches			Operation(s) involving Eyes		
Unconsciousness for any reason			Operation(s) involving Brain		
Dizziness or fainting spells			Operation(s) involving Heart		
Heart Trouble:			Operation(s) involving Nerves		
Coronary Artery Disease or Angina			Operation(s) involving Blood Vessels		
Valve Disease			Operation(s) involving Bones		
Left Bundle Brach Block			Diabetes		
Abnormal Cardiac Rhythms			Eye Trouble (exclude glasses)		
High Blood Pressure			Asthma		
Any Drug / Narcotic / Alcohol Problems			Anemia or other blood diseases Including abnormal bleeding		
Psychiatric / Mental health Problems					
Contact Lenses			Injuries, Illnesses and/or Admission to a hospital in the past 12 months		
Dentures					
Amputations / Physical Disability			Illness(s) not mentioned above		
Hay Fever			Allergy(s) to medications (list)		

Date of Last Tetanus:_____ Blood Type (if known):_____

Comments:

_____

Medications Used (including eye drops):

_____

_____

Emergency Contact :

Primary Contact:_____ Phone#:_____ At the track: YES NO

Secondary Contact:_____ Phone#:_____ At the track: YES NO

I certify that these statements are true and accurate and I give my permission to any hospital, institution, or physician, to furnish any information to the medical personal at The Texas Mile™.

Participant Signature:_____ Date:_____