

Houston Chapter Drivers' School Medical Information

In case of an accident, this information could save your life. Please complete this form as completely and accurately as possible. The completed form should be turned in when you register at the track. This information will be kept strictly confidential and released only to medical personnel in case of an emergency.

PERSONAL INFORMATION

Name	Social Security Number
Street Address	Date of Birth
City, State, Zip Code	

MEDICAL INSURANCE INFORMATION

Name of Medical Insurance Company	Your Identification Number	Medical Policy/Group Number
Phone Number for Benefit Verification <i>Include Area Code</i>	Name of Your Employer	

MEDICAL INFORMATION

Name of Personal Physician	Telephone Number of Personal Physician <i>Include Area Code</i>	Blood Type
Street Address of Personal Physician (include Street, City, State and Zip Code)		

List Current Medication(s) and Dosage(s)	List Known Allergies to Medication
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List any health problems, allergies, medical conditions or other information that you would want medical personnel to know in case of an emergency

EMERGENCY NOTIFICATION

Name of Person to Be Notified in Emergency	Relationship	Daytime Phone (include area code)	Evening Phone (include area code)
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Address of Person Named Above for Emergency Notification (Street, City, State and Zip Code)

Signature _____ Date _____