

**2009 - 2010 CLUB 420 ASSN/USSCMC CLINICS  
HEALTH CARE AND EMERGENCY INFORMATION  
AND  
AUTHORIZATION FOR HEALTH CARE TREATMENT**

NAME: \_\_\_\_\_ GENDER \_\_\_\_\_ (M) \_\_\_\_\_ (F)

ADDRESS: \_\_\_\_\_  
*Street/P.O. Box*

\_\_\_\_\_  
*City State Zip*

TELEPHONE \_\_\_\_\_ (R) \_\_\_\_\_ (B)

DATE OF BIRTH: \_\_\_\_\_

ADULT RESPONSIBLE FOR COMPETITOR AT EVENT: \_\_\_\_\_

ADULT'S CELL #: \_\_\_\_\_

PLEASE ANSWER THE FOLLOWING QUESTIONS AS COMPLETELY AS POSSIBLE:

Please check those that apply: (Provide necessary details below)

CHRONIC AILMENTS:	ALLERGIES:
ASTHMA, OR OTHER RESPIRATORY PROBLEMS	MEDICATION
DIABETES OR HYPOGLYCEMIA	BEE STINGS/INSECT BITES
HEMOPHILIA, OR OTHER BLEEDING PROBLEMS	FOODS
CIRCULATORY OR HEART PROBLEMS	OTHERS, IF SIGNIFICANT
EPILEPSY	

CURRENT MEDICATIONS, IF ANY: \_\_\_\_\_

DETAILS: \_\_\_\_\_

HEALTH INSURANCE CARRIER: \_\_\_\_\_ Certificate # \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ Phone # \_\_\_\_\_

