CVMA Medical Information and Treatment Release

Competition # ___________

Name (printed): ____

Address: ____
Street City State Zip Code

Phone: (   ) _____- ________ Date of Birth (mm/dd/yyyy): _______________

Emergency Contacts:

Primary Contact (printed): ____

Address: ____
Street City State Zip Code

Phone: _________________________ Alternate Phone: __________________

Secondary Contact (printed): ____

Address: ____
Street City State Zip Code

Phone: _________________________ Alternate Phone: __________________

Insurance Information:

Name of Provider: ___________________ Policy #: ______________________

Group/Plan Name: ___________________ Phone: ________________________

Medical Information:

Name of Doctor (printed): ____

Address: ____
Street City State Zip Code

Phone: _________________________ Alternate Phone: __________________

Chuckwalla Valley Motorcycle Association
P.O. Box 307, Desert Center, CA 92239
Phone: 760.227.3100 | fax: 760.227.3111

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Please check the box if you have had any of the following conditions:

☐ Heart disease

☐ High Blood Pressure

☐ Diabetic Taking Insulin

☐ Contact Lenses

☐ Dentures

☐ Seizures or Epilepsy

☐ Head Injuries (if so, provide date) ____________________________________

List all medications regularly taken ____________________________________

Medicine allergies ____

The undersigned, on behalf of himself or minor, if applicable, hereby authorizes and consents to any X-Ray, examination, anesthetic, medical or surgical diagnostic or treatment and hospital care, to be rendered under the general or special supervision and upon the advice of a physician and surgeon licensed under the provisions of the California Medicine Practices Act, and does hereby authorize and consent to any X-Ray, examination, anesthetic, dental or surgical diagnostic or treatment and hospital care to be rendered by a dentist under the provisions of the California Dental Practices Act.

Name (print): ____

Signature ______________________________________ Date: ________________________

Name and signature of parent or legal guardian if applicable:

Name (print): ____

Signature ______________________________________ Date: ________________________

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