THE GUYANA MOTOR RACING & SPORTS CLUB

COMPETITOR MEDICAL INFORMATION

*Please answer **ALL** questions*

COMPETITOR NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

NATIONALITY: _____ TELEPHONE: _____

NAME OF CONTACT PERSON *(In case of emergency):* _____ BLOOD GROUP _____

ADDRESS: _____

TELEPHONE: _____

MEDICAL HISTORY

(write YES or NO answers)

Do you suffer from any of the following:

1. Allergies to: (a) Medication _____ (b) Any other _____
2. Fits, Convulsions, Epilepsy or Blackouts _____
3. Diabetes or Low Blood Sugar _____
4. High Blood Pressure _____
5. Heart problems (Heart Attacks, Irregular Heart Beat, Abnormal Heart Sounds, etc.) _____
6. Respiratory problems (Asthma, Bronchitis, etc.) _____
7. Any mental disorder _____
8. Visual problems: (a) Do you wear glasses or contact lenses _____ (b) Are you colour blind _____
9. Musculoskeletal problems (restriction of movement of any limb or arthritis, etc.) _____
10. Any blood disorder e.g. Sickle Cell disease _____
11. Any other significant medical history _____

Please explain any YES answers: _____

_____

_____

IS THE COMPETITOR FIT TO DRIVE OR RIDE _____

SIGNATURE OF AUTHORISED PHYSICAN: _____ DATE: _____

NOT VALID WITHOUT SIGNATURE & STAMP FROM A DOCTOR