



USFRA DRIVERS MEDICAL FORM

ONE FORM PER DRIVER REQUIRED



CLASS: _____ VEHICLE # _____

NAME: _____

SOCIAL SEC. # _____ (OPTIONAL)

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOSPITALIZATION INSURANCE Co. _____ POLICY# _____

PERSONAL PHYSICIAN _____ PHYSICIAN PHONE# _____

BIRTH DATE _____ BLOOD TYPE _____

DRUGS, MEDICATIONS, ALLERGIES _____

PERSON TO NOTIFY IN EMERGENCIES name: (1st) _____ phone: _____

name: (2nd) _____ phone: _____

CONDITIONS YOU HAVE OR HAVE HAD IN THE PAST
(PLEASE CHECK ALONG SIDE IF ONE OR MORE ITEMS APPLY TO YOU)

- Diabetes
- Heart Disease
- Head Injuries
- High Blood Pressure
- Seizure disorder
- Pace Maker
- Arrhythmia
- Malignancy
- Other _____
- None
- Asthma/Respiratory Problems
- Blood Problems (Anemia, Clotting difficulties)
- Musculoskeletal Problems

PAST SURGICAL HISTORY _____

SOCIAL HISTORY:

- Do you smoke?
- Do you drink alcohol?

Emergency Authorization: In the case of emergency wherein I am incapable of giving consent due to illness or injury. I hereby authorize any qualified person to administer first aid and/or other necessary treatment.

SIGNED: _____ DATE: _____

Emergency Surgical Authorization: In case of emergency wherein I am incapable of giving consent due to illness or injury, I hereby authorize any licensed surgeon, and his choice of anesthesiologist to perform surgery, if necessary. The need for surgery must be agreed upon by (2) physicians qualified to make such judgement.

SIGNED: _____ DATE: _____

Donor Authorization: In the hope that I may help others. I hereby make this anatomical gift, if medically acceptable, to take effect upon my death. The words and marks below indicate my desires to give (a) any organs or parts. (b) only the following organs or parts.

SPECIFY THE ORGANS OR PARTS: _____

SIGNED: _____ WITNESS: _____

DATE: _____ DATE: _____