

***“The Off-Road Experience”***  
***EMERGENCY MEDICAL*** *One form per person*

*Name:* \_\_\_\_\_ *Date:* \_\_\_\_\_

*Address:* \_\_\_\_\_

*City:* \_\_\_\_\_ *St:* \_\_\_\_\_ *Zip:* \_\_\_\_\_

*Phone:* \_\_\_\_\_ *Phone:* \_\_\_\_\_

*Date of Birth:* \_\_\_\_\_ *Sex:* \_\_\_\_\_

*Drivers License#* \_\_\_\_\_ *St:* \_\_\_\_\_

*Passport#* \_\_\_\_\_ *Country:* \_\_\_\_\_ *(foreign guests only)*

*Emergency Contact:* \_\_\_\_\_ *Relation:* \_\_\_\_\_

*Phone:* \_\_\_\_\_ *Phone:* \_\_\_\_\_

*Do you have any medical conditions? Yes ( ), No ( ). If so, Explain:* \_\_\_\_\_

*Do you have any Allergies? Yes ( ), No ( ). If so, Explain:* \_\_\_\_\_

*Are you taking any Medication? Yes ( ), No ( ). If so, Explain:* \_\_\_\_\_

*Do you have any dietary restrictions? Yes ( ), No ( ). If so, Explain:* \_\_\_\_\_

*Do you carry Medical Insurance? Yes ( ), No ( ). Provider:* \_\_\_\_\_

*Describe your current physical fitness & level of activity:* \_\_\_\_\_