

Medical Emergency Form

Please Print

Name: _____ Birth Date: _____

Address: _____ S.S. # _____

City: _____ State: _____ Zip: _____

Telephone: _(____)_____

Allergies: _____

Current Medications: _____

Date of last Tetanus Booster: _____ Blood Type: _____

Previous Hospital Trips with Date: _____

Other Medical information: _____

Physician: _____ Phone: _(____)_____

Address: _____ City: _____ St: _____

Insurance: through Interstate Racing Association

K & K Insurance

1712 Magnavox Way

P.O. Box 2388

Fort Wayne, IN 46801-2338

800-348-1839 Fax: 219-459-5118

Member number: _____

Group number: _____

Person to contact in case of emergency:

Name: _____ Phone: _(____)_____

Additional Person: _____ Cell:_(____)_____

Name: _____ Phone: _(____)_____

Cell:_(____)_____

Signature: _____ Date: _____

Must be filled out with insurance form and returned at same time.