

**ARIZONA DRAG BOAT ASSOCIATION  
MEDICAL INFORMATION FORM**

Boat # \_\_\_\_\_

Class # \_\_\_\_\_

THIS FORM GOES TO THE MEDICAL AND RESCUE PERSONNEL AT EACH RACE

Participants full name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Spouses Name/Next of Kin/Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Medications Currently Using: (Prescribed and/or OTC) \_\_\_\_\_

Medical Allergies: \_\_\_\_\_

Past Medical History: \_\_\_\_\_

High Blood Pressure: Yes / No    Heart Disease: Yes / No    Asthma: Yes / No

Other: \_\_\_\_\_

Do you have hospitalization insurance? Yes / No

**INSURANCE AFFIDAVIT**

Company: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

I, The undersigned, hereby certify that I have in effect a hospitalization policy of limits not less than ten thousand (\$10,000) dollars. I further certify that I shall first file and and all claims for damages, personal injury and/or accidents through my insurance carrier prior to relying on any insurance provided by the Arizona Drag Boat Association.

My Beneficiary is: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Participants Signature: \_\_\_\_\_ Date: \_\_\_\_\_

ADBA Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_