



*Original*  
**Pizza Logs™**

**600 SPRINT TOUR**



**DRIVER HEALTH INFORMATION FORM**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

OVER THE AGE OF 18? \_\_\_\_\_ YES \_\_\_\_\_ NO

IF NO, DATE OF BIRTH \_\_\_\_ / \_\_\_\_ / \_\_\_\_

INSURANCE CARRIER : \_\_\_\_\_

INSURANCE # \_\_\_\_\_

Does your insurance require a pre-approval phone call? \_\_\_\_\_ yes \_\_\_\_\_ no

Doctors Name: \_\_\_\_\_

Doctors Telephone Number: \_\_\_\_\_

**IN CASE OF EMERGENCY NOTIFY:**

Name : \_\_\_\_\_

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

\_\_\_\_\_

Relationship: \_\_\_\_\_

Alternate Name : \_\_\_\_\_

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

\_\_\_\_\_

Relationship: \_\_\_\_\_

**LIST ALL MEDICATIONS (INCLUDING OTC) YOU TAKE ON A REGULAR BASIS:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(TURN OVER)

PLEASE EXPLAIN ANY AREAS IN PARTS I-IV THAT ARE CHECKED. INDICATE ANY INFORMATION USEFUL TO THE MEDICAL PROFESSIONAL IN CHARGE THAT WILL AID IN MEDICAL TREATMENT.

**Part I: ILLNESS AND CHRONIC OR RECURRING INJURIES (please check those that apply)**

Asthma                       Bleeding/clotting Disorders                       Constipation                       Diabetes  
 Ear infections                       Heart Defect Disease                       Nosebleeds                       Fainting  
 Hypertension                       Seizure Disorder                       Mononucleosis                       Convulsions

Others (please specify) \_\_\_\_\_

**Part II ALLERGIES \*(check those that apply and specify nature of allergic reaction)**

Animals                       Hay Fever                       Pollen                       Food  
 Insect sting                       Medicines/drugs                       Plants                       Penicillin  
 Others (please specify) : \_\_\_\_\_

**Part III OTHER CONDITIONS (list any medical conditions not listed above)**

**Part IV DO YOU HAVE ANY MEDICAL RESTRICTIONS THAT MIGHT EFFECT YOUR MEDICAL TREATMENT**

(D.N.R., no blood transfusion, etc., please specify and attach any applicable forms or documentation):

GIVE DATES OF IMMUNIZATIONS:    Tetanus \_\_\_\_\_    Other \_\_\_\_\_

HAVE YOU HAD THE HEPATITUS B VACCINE?    \_\_\_\_\_ if yes, date \_\_\_\_\_    \_\_\_\_\_ No

**THIS HEALTH STATEMENT IS COMPLETED AND TRUE TO THE BEST OF MY KNOWLEDGE**

Signature \_\_\_\_\_ Date: \_\_\_\_\_  
Driver (parent/guardian if not 18 years old)