CISA Advanced Racing Clinic
Medical Release

Please complete, sign and return this form to:
CISA Adv Race Clinic
2812 Cañon Street
San Diego, CA 92106

Participant's Name: _____

Participant's E-Mail Address: _____

Participant Address: _____

City, State, Zip: _____

Family Physician: _____

Physician Tel: (_____)_____ Physician Cell: (_____)_____

Insurance Co.: _____ Policy Number: _____

Have you been treated for:

___Rheumatic fever ____Heart disease ____Chronic disease of the lung

___Asthma ____Chronic ear disease ____Disease of the bones of joints

___Epilepsy Other: _____

Any vision or hearing defect _____

Do you wear contact lenses? Yes No

Last Physical Examination: _____

I, the undersigned, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any member of the medical staff licensed under the provisions of the Medical Practice Act or a dentist licensed under the provisions of the Dental Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the State of California Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power to render car which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

Signed:_____ Date:_____
(if over 18) Signature of Participant
(if under 18) Signature of Father, Mother or Guardian
In Case of Emergency, Please notify:

Name:_____ phone:_____

Name: _____ phone:_____