

# CISA Advanced Racing Clinic Medical Release



Please complete, sign and return this form to:  
CISA Advanced Race Clinic  
6216 E Pacific Coast Highway #170  
Long Beach, CA 90803

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:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Chronic disease of the lung    |
| <input type="checkbox"/> Asthma          | <input type="checkbox"/> Chronic ear disease | <input type="checkbox"/> Disease of the bones of joints |
| <input type="checkbox"/> 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 care 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: \_\_\_\_\_