DRIVER MEMBER MEDICAL FORM

Name _____ Age ____ Date of Birth_____

Address_____City, St., Zip:_____

Email Address_____Occupation _____

Phone (H)_____ (W) _____(C)_____

PLEASE INDICATE IF YOU EVER HAD, OR HAVE NOW, ANY OF THE FOLLOWING:

Do You Have or Have You Ever Had?	**Yes**	**No**	**Do You Have or Have You Ever Had?**	**Yes**	**No**
Frequent or Severe Headaches			Any drug, narcotic or alcohol problems		
Unconsciousness for any reason			Psychiatric/mental health problems		
Dizziness or fainting spells			Eye trouble (except glasses)		
Epilepsy or seizures			Asthma		
Coronary artery disease or angina			Diabetes requiring insulin		
Heart valve disease			Anemia or other blood diseases including abnormal bleeding		
Left Bundle Branch Block (heart)			Admission to a hospital in the past 12 months for any reason		
Abnormal cardiac rhythms			Allergy(s) to medications – List		
High blood pressure			Routine use of Pain Medication		
Operation(s) on brain			Amputations/physical disability		
Operation(s) on heart			Illness(es) not listed above. List:		
Operation(s) on eyes, nerves, blood vessels or bones			Do you require the use of supplemental oxygen or other external breathing device?		
Previous waiver(s) from another sanctioning body for medical condition(s). List:			Previous denials from any sanctioning body due to Medical reasons.		

Blood Thinner Medication (circle) YES NO

Comments and details of any condition noted above or on the back of this form. Please list all medications including eye drops.

_____

Driver Signature_____**Date** _____