AMERICAN MOTORCYCLIST ASSOCIATION

MEDICAL HISTORY FORM

(to be completed by the applicant)

Personal Data:

Name:	First name:	Date of birth	
Address:			
Sex male female		FMN:	AMA / CMA

No		Yes	Details
☐	Loss of consciousness for any reason dizziness or headache	☐	
☐	Eye problems (except glasses)	☐	
☐	Asthma	☐	
☐	Allergy to medicines or drugs	☐	
☐	Concussions (number/date)	☐	
☐	Diabetes	☐	
☐	Heart problems	☐	
☐	Blood pressure disorder	☐	
☐	Stomach problems (ulcer, etc)	☐	
☐	Uro-genital problems	☐	
☐	Epilepsy or convulsions	☐	
☐	Mental or nervous disorder	☐	
☐	Problems with arms or legs incl, muscle cramp or joint stiffness	☐	
☐	Blood disorder with tendency to bleeding	☐	
	Blood type	☐	
☐	Operations (fractures/hardware)	☐	
☐	Do you take any medicine or drugs regularly?	☐	

a. I have not been banned, on medical grounds, from taking part in any other sport.
b. I do not take drugs and do not abuse alcohol.
c. In case of an injury I give permission to the Medical Staff to release any relevant information to the clerk of the course, my relatives, my own doctor and the FMN.
d. I declare that the information that I have given is the truth.
e. I agree to the information on the Medical Examination Form being sent to the doctor of my FMN.

Date Signature of applicant (or responsible Parent or Guardian if a minor)