New England Hillclimb Association (NEHA) | www.hillclimb.org

EMERGENCY TREATMENT AND RELEASE FORM

DRIVER INFORMATION

Name: _____ Birth Date: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

PHYSICIAN & HOSPITAL INFORMATION

Name of Primary Physician: _____ Phone #: _____

Physician Address: _____

City: _____ State: _____ ZIP: _____

Name of Treating Hospital: _____ Phone: _____

Hospital City: _____ State: _____ ZIP: _____

Medical Records Number: _____

EMERGENCY CONTACT INFORMATION

In case of emergency contact the following person

Name: _____ Relationship: _____

Phone Number (primary): _____ Phone Number (secondary): _____

MEDICAL INFORMATION

Information needed to assist first responders and any subsequent medical treatment

Current Medications: _____

Current Medical Issues: _____

Allergies: _____

Check all that apply:
Diabetic ☐ | Contact Lenses ☐ | Hearing Aid ☐ | False Teeth ☐ | Heart Trouble ☐

Date of Last Tetanus Shot: _____ Blood Type: _____

AUTHORIZATION

I, _____ hereby authorize any medical treatment by the first responders along with any physician, surgeon, or staff attached to an accredited hospital or medical facility, if such treatment should be deemed necessary.

CAR NUMBER

Name: (please print): _____

Signature _____ Date: _____
(Parent of Guardian must sign if card is made out for a minor)