*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/Town: | | |  | | | | | 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** | | | | | | | | | | | | | | | | | |
| |  | | --- | | **CAR NUMBER** | |  |   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.  Name: (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Parent of Guardian must sign if card is made out for a minor) | | | | | | | | | | | | | | | | | |