



IMSA Medical Liaison Department
Toni Wright

Senior Medical Liaison Coordinator

Office: (386) 310-6434

Fax: (386) 310-6435

Ashlee Rice

IMSA Medical Administrative Assistant

Office: (386) 310-6438

Fax: (386) 310-6439

Dear Minor-Aged Driver and Parent or Legal Guardian,

Please find enclosed the 2017 MINOR Competitor History & Physical Examination, MINOR HIPAA (Authorization for Release of Medical Information), MINOR Medical Consent and ImPACT Testing Submission forms.

Due to applicable laws in the various states in which you may compete, IMSA requires all drivers who are 18 and under at the time of his/her initial 2017 on-track participation to sign applicable forms for MINOR drivers. If you are 18 or under, please ensure the forms provided herein are labeled for Minor Drivers and are signed by your parent(s) or legal guardian. If you have not received the correct forms based upon your age, please contact the Medical Liaison Department for the appropriate documents.

Accurate medical information is vitally important. Please thoroughly complete pages one and two of the History form and sign in the designated locations of page three along with a parent or legal guardian. Your personal physician should complete and sign the Physical Exam form based on their review of your medical information and physical exam. Review and complete the top portion of the HIPAA Authorization form, initial lines A–G, and sign and date the bottom along with a parent or legal guardian. The minor medical consent also needs to be fully completed and signed by a parent or legal guardian in the spaces provided. Finally, if not already on file, you are required to submit documentation of an ImPACT test completed within the past two years. For any drivers not racing in any IMSA sanctioned races, submission of an ImPACT test is not required.

You are advised to schedule your physical examination in a timely manner and ensure that a licensed physician will be available to sign or co-sign your form (signatures of Physician Assistants or Nurse Practitioners will not be accepted). All forms must be received by the Medical Liaison Department prior to any 2017 on-track participation in any IMSA sanctioned events. Please retain a copy for your records and return all original forms to:

IMSA Medical Liaison Department
One Daytona Blvd.
Daytona Beach, FL 32114

Do not enclose these forms with any documents sent to other IMSA departments or representatives.

If you need assistance while completing your forms, please feel free to contact the Medical Liaison Department. Once these requirements have been fulfilled, your information will be applied across all IMSA-sanctioned series in which you may compete and you will not be required to duplicate this process for other IMSA series for the 2017 season. We thank you in advance for your cooperation.

Sincerely,
Medical Liaison Department
Enclosures

MEDICAL FORM REQUIREMENTS FOR AGE & SERIES

	WeatherTech, Continental Tire, Prototype Lites, GT3 Cup U.S. and Canada, Lamborghini, Ferrari
Age 19 and Over	<ul style="list-style-type: none">• Medical History form with driver signature• Physical signed by physician (M.D. or D.O.)• HIPAA Form, Initial A-G, signed at bottom• Valid ImPACT test dated within the last two years
Age 18 and Under	<ul style="list-style-type: none">• Medical History form with driver & parental or legal guardian signatures• Physical signed by physician (M.D. or D.O.)• HIPAA Form, Initial A-G, with driver & parental or legal guardian signatures• Consent for Treatment of a Minor form (signed by parent or legal guardian)• Valid ImPACT test dated within the last two years

2017 IMSA Minor Competitor History and Physical

Submit Original Documents DIRECTLY to the Medical Liaison's Office

Pages 1 - 3 to be completed by Competitor, Parent or Guardian and reviewed with Examining Physician

Page 4 to be completed by Examining Physician

Submission of this form with documented Physician's exam is required prior to any IMSA sanctioned on-track activity.

PLEASE PRINT CLEARLY

Legal Last Name	Legal First Name	Nick Name

Age	Date of Birth (Month/Day/Year)	Gender	Marital Status
		M F	S M

Home Address	City	State	Zip/Country
Mailing Address	City	State	Zip/Country
Home Phone	Cell Phone	Email	

EMERGENCY CONTACTS (List two)			
Name	Relationship	Home Phone	Cell Phone
	<input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian		

IMSA Series & Number of Race Vehicle		
<input type="checkbox"/> WeatherTech Championship <input type="checkbox"/> Continental Tire Challenge	<input type="checkbox"/> Prototype Lites Porsche GT3 Cup <input type="checkbox"/> US <input type="checkbox"/> Canada	<input type="checkbox"/> Ferrari Challenge <input type="checkbox"/> Lamborghini Super Trofeo

Team Name	Entrant	Garage/Shop #
Name of PR Contact	Email	Cell Phone

Personal Primary Care Physician		<input type="checkbox"/> No Current Primary Care Physician	
Name	Specialty		
Address	City	State	Zip/Country
Office Phone	Office Fax		

ALLERGIES			
Medication Allergies <input type="checkbox"/> NONE		Reactions might include symptoms such as: hives, rash and/or trouble breathing	
Medication:		Reaction:	
Medication:		Reaction:	
Medication:		Reaction:	
Medication:		Reaction:	
Allergies to Insects, Food, Latex, Other <input type="checkbox"/> NONE		Reactions might include symptoms such as: hives, rash and/or trouble breathing	
Allergy:		Reaction:	
Allergy:		Reaction:	
Allergy:		Reaction:	
Allergy:		Reaction:	

MEDICATIONS			
Including <u>ALL</u> prescription <u>and</u> routine Over the Counter Medications, Vitamins, Workout Supplements, Herbs, etc.			
<input type="checkbox"/> NONE			
Name of Medication	Dose	Frequency/Regimen	Date Started

2017 IMSA Minor Competitor History and Physical

Last Name: _____ First Name: _____

Have you **EVER** experienced any of the following? Please respond to **EACH** line item, place check mark next to the appropriate diagnosis or symptom if applicable and explain any **YES** response in the space below.

General			Gastrointestinal		
<input type="checkbox"/> Anemia <input type="checkbox"/> Blood Disease	YES	NO	Bowel Problem	YES	NO
Anesthesia Complications	YES	NO	Hernia	YES	NO
Burns	YES	NO	<input type="checkbox"/> Liver Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Cirrhosis	YES	NO
Depression	YES	NO	<input type="checkbox"/> Stomach Ulcer <input type="checkbox"/> Reflux	YES	NO
<input type="checkbox"/> Difficulty Sleeping <input type="checkbox"/> Sleep Apnea	YES	NO	Neurological		
High Cholesterol	YES	NO	<input type="checkbox"/> ADD <input type="checkbox"/> ADHD	YES	NO
Seasonal Allergies	YES	NO	<input type="checkbox"/> Concussion <input type="checkbox"/> Head Injury	YES	NO
<input type="checkbox"/> Skin Problem <input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema	YES	NO	<input type="checkbox"/> Dizziness <input type="checkbox"/> Vertigo <input type="checkbox"/> Motion Sickness	YES	NO
Cardiac			<input type="checkbox"/> Fainting <input type="checkbox"/> Syncope <input type="checkbox"/> Loss of Consciousness	YES	NO
<input type="checkbox"/> Angina <input type="checkbox"/> Chest Pain <input type="checkbox"/> Coronary Artery Disease	YES	NO	<input type="checkbox"/> Headaches <input type="checkbox"/> Migraines	YES	NO
High Blood Pressure	YES	NO	Memory Loss	YES	NO
<input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Palpitations	YES	NO	<input type="checkbox"/> Seizures <input type="checkbox"/> Epilepsy	YES	NO
Peripheral Vascular Disease (Circulatory Problem)	YES	NO	<input type="checkbox"/> Stroke <input type="checkbox"/> TIA	YES	NO
<input type="checkbox"/> Valve Disease <input type="checkbox"/> Valve Replacement	YES	NO	Orthopedic		
Implanted pacemaker	YES	NO	<input type="checkbox"/> Amputations <input type="checkbox"/> Prosthesis (List sites below)	YES	NO
Automatic Implantable Cardioverter Defibrillator (AICD)	YES	NO	<input type="checkbox"/> Back <input type="checkbox"/> Spine Problem	YES	NO
Pulmonary			Broken Bones (Fractures)	YES	NO
<input type="checkbox"/> Asthma <input type="checkbox"/> Reactive Airway Disease	YES	NO	Implanted Metal Plates, Pins or Screws (List sites below)	YES	NO
Bronchitis	YES	NO	<input type="checkbox"/> Joint <input type="checkbox"/> Muscle Problem	YES	NO
Emphysema	YES	NO	Neck Problem	YES	NO
Endocrine			Genitourinary		
Diabetes	YES	NO	<input type="checkbox"/> Kidney <input type="checkbox"/> Bladder <input type="checkbox"/> Urinary Problem	YES	NO
Thyroid disorder	YES	NO	Prostate Problem	YES	NO
Eyes, Ears, Nose, Throat			Social		
Nose Bleeds	YES	NO	Tobacco use including smokeless tobacco	YES	NO
Throat Problem	YES	NO	Alcohol use	YES	NO
<input type="checkbox"/> Hearing Deficit <input type="checkbox"/> Hearing Loss	YES	NO	Recreational drugs	YES	NO
Do you use a hearing aid? <input type="checkbox"/> Right <input type="checkbox"/> Left	YES	NO	Please explain any YES responses		
Vision Deficit or Loss	YES	NO	<div style="border: 1px solid black; min-height: 100px;"></div>		
Corrective Eye Surgery (ex. Lasik, PRK) <input type="checkbox"/> Right <input type="checkbox"/> Left	YES	NO			
Do you use contact lenses?	YES	NO			
Do you use contact lenses while driving race vehicle?	YES	NO			
Do you use corrective glasses?	YES	NO			
Do you use corrective glasses while driving race vehicle?	YES	NO			
Do you use corrective sunglasses?	YES	NO			
Do you use corrective sunglasses while driving race vehicle?	YES	NO			
Do you wear dentures?	YES	NO			
Do you wear partial dental prosthesis?	YES	NO			
			Any other injury, symptom or medical condition not otherwise listed:		
			1.		
			2.		
			ImPACT/Neurocognitive Testing		
			(Required for all drivers racing in IMSA sanctioned events)		
			Date of most recent test: <input type="checkbox"/> Baseline <input type="checkbox"/> Post Injury		

2017 IMSA Minor Competitor History and Physical

Last Name: _____ First Name: _____

Hospitalizations (include any/all overnight hospital admissions) <input type="checkbox"/> NONE
Date: ____/____/____ Reason: _____
Date: ____/____/____ Reason: _____
Date: ____/____/____ Reason: _____
Prior Surgical History <input type="checkbox"/> NONE
Date: ____/____/____ Reason: _____
Date: ____/____/____ Reason: _____
Date: ____/____/____ Reason: _____

I certify that the information I have provided here, or that I may provide to the International Motor Sports Association ("IMSA") or its affiliates in the future, is correct and complete. I further certify that I/the minor believe I/the minor am physically and psychologically fit to compete in motor vehicle racing in the 2017 IMSA season and I have no knowledge of any reason why I should not be allowed to compete. If at any time I do not personally believe that I am physically or psychologically fit to compete for any reason, I will advise the IMSA Medical Liaison's Office in writing of my concern for my own fitness as soon as possible. I also certify that should there be any change in my health status, information or medications that I will inform the Medical Liaison's Office in writing of such change(s) as soon as practically possible, but in no event longer than five (5) business days of my discovery of such change(s).

MINOR COMPETITOR SIGNATURE: _____ **Date:** _____

I hereby acknowledge that I am a parent or legal guardian of the above signed minor and authorized by law to sign on the minor's behalf, and that I agree all the information provided herein is correct to the best of my knowledge and I have no knowledge of any reason why said minor should not be allowed to compete. If at any time I do not personally believe that said minor is physically or psychologically fit to compete for any reason, I will advise the IMSA Medical Liaison's Office of my concern for the minor's fitness in writing as soon as possible. I also certify that should there be any change in the minor's health status, information or medications, that the minor and/or parent/legal guardian will inform the Medical Liaison Department of such change(s) as soon as practically possible, but in no event longer than five (5) calendar days of my discovery of such change(s).

PARENT/LEGAL GUARDIAN SIGNATURE: _____ **Date:** _____

ADULT WITNESS SIGNATURE: _____ **Date:** _____

2017 IMSA Minor Competitor History and Physical

Last Name: _____ First Name: _____

PHYSICAL EXAM

Date of Exam: _____ Height: _____ (ft) _____ (in) Weight: _____ (lbs) (Actual weight on date of physical exam)

Vital Signs

Temperature: _____ (°F) Pulse: _____ Rhythm: _____ Respirations: _____ Blood Pressure: _____ / _____

Most Recent Tetanus Immunization: _____ UNKNOWN (if unknown, booster recommended)

Snellen Visual Acuity		
	Without Corrective Lenses	With Corrective Lenses/Glasses
LEFT EYE (OS)	20 /	20 /
RIGHT EYE (OD)	20 /	20 /
Binocular (OU)	20 /	20 /

Body Systems		
	√ = Normal Exam	Abnormal Findings
General Appearance		
Head		
Eyes		
Ears		
Oropharynx		
Neck / Thyroid		
Chest		
Heart		
Lungs		
Back		
Spine		
Abdomen		
Pelvis		
Extremities		
Joints		
Peripheral Pulses		
Skin		
Mental Status		
Neurological		
Gait		

The undersigned Physician has reviewed the medical history and conducted a thorough physical examination on the patient identified above. As a result of that review and examination, the undersigned Physician finds no signs, symptoms or conditions that would preclude the patient from participating in motor vehicle racing. The patient is medically cleared to compete in all motor vehicle racing activities without restrictions.

Examining Physician Name (please print clearly): _____

Physician Signature: _____ Date: ____/____/____

*****Physician Assistant or Nurse Practitioner signatures must have Physician co-signature***
This form will not be accepted unless signed by a Physician**

Physician's License #: _____ State/Country: _____ Expiration: _____

Office Address: _____ City: _____ State: _____ Zip/Country: _____

Office Phone: (____) _____-_____ Office Fax: (____) _____-_____

**HIPAA AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION
(MINOR DRIVERS / COMPETITORS)**

Name: _____ Telephone: (_____) _____ Date of Birth: _____
Address: _____

This Authorization Form describes different uses and disclosures of health information, including as protected under state law and also "protected health information" as defined by the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the regulations promulgated thereunder. Unless otherwise revoked by me in writing, this Authorization expires twelve (12) months after the date of signing this Authorization ("Expiration Date").

I hereby authorize the following uses and disclosures of my Health Information, as defined below, and as permitted or required by law:

(initial) **A. General.** I specifically authorize and direct any physician, healthcare provider, hospital or other healthcare facility who provided or is providing assessment, diagnosis, care, treatment or services to me prior to execution of this Authorization and/or any time after execution of this Authorization up to the Expiration Date, including their agents, employees and medical staff (collectively "Health Care Provider") to release my "Health Information" (as defined below) to (1) the IMSA Medical Liaison Department and/or their designated agents and employees (collectively "Medical Liaison Department"); and/or (2) IMSA's Substance Abuse Policy's designated Medical Review Officer or its designated agent (collectively "Medical Review Officer") as requested by them for the purposes of safety, quality assurance/quality improvement, my ability or eligibility to compete, and/or my assessment, treatment or care, whether related to a medical, psychological, psychiatric, or substance abuse condition. *"Health Information" is defined as: the full and complete medical record; hospital chart; medical history; notes; reports; data; test results; radiology reports, images and films (such as CT, MRI, and x-ray); documents related to examination or treatment for any physical or mental health condition, sickness or injury; assessments; diagnoses; prognoses; medications and prescriptions; insurance records; physician notes of patient interviews; privileged or private communications; and any and all other health information or records regarding my health or treatment, including correspondence, patient notes, and phone messages. I understand Health Information includes records disclosed to the Health Care Providers by other healthcare providers and facilities who previously provided treatment to me, and that it may include information and records protected under state law (such as certain conditions) and federal law (such as alcohol or drug abuse).*

(initial) **B. Contagious, Infectious, or Communicable Disease.** I specifically authorize and direct any Health Care Provider to release to the Medical Liaison Department, and/or to the Medical Review Officer any Health Information about me regarding assessment, diagnosis, care or treatment of a contagious, infectious or communicable disease (including, but not limited to, HIV/AIDS information, tuberculosis, measles, negative/positive diagnosis, testing, test results, status and treatment), if applicable.

(initial) **C. Mental Health Information.** I specifically authorize and direct any Health Care Provider to release to the Medical Liaison Department, , and/or to the Medical Review Officer any Health Information about me regarding assessment, diagnosis, care or treatment of a mental health condition, illness, or disease, if applicable, for the purposes of safety, quality assurance/quality improvement, my ability or eligibility to compete, and/or for my assessment, treatment or care. This Authorization does not include the release of "psychotherapy notes" (as that term is defined by HIPAA) recorded by a healthcare provider who is a mental health professional regarding a counseling session, but only if such notes are held separately from my medical record. This Authorization does include, for example, all information held in my medical record, other professional notes, medication prescriptions and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

(initial) **D. Alcohol/Drug Abuse.** I specifically authorize and direct any Health Care Provider to release to the Medical Liaison Department and/or to the Medical Review Officer any Health Information about me regarding assessment, diagnosis, care, treatment or referral regarding alcohol and/or drug abuse, if applicable, for the purposes of safety, quality assurance/quality improvement, my ability or eligibility to compete, and/or for my assessment, treatment or care.

(initial) **E. Discussion Permitted.** I specifically authorize and direct any Health Care Provider to discuss, clarify or explain my Health Information with the Medical Liaison Department and/or the Medical Review Officer, upon their request, for the purposes of safety, quality assurance/quality improvement, my ability or eligibility to compete, and/or for my assessment, treatment or care.

(initial) F. Disclosure by Medical Liaison for Certain Purposes. I authorize the Medical Liaison Department to use and disclose my Health Information in their possession, including but not limited to my IMSA Driver History & Physical Forms, Track Incident Medical Reports, and Infield Care Center Reports, to the following: (1) physicians, health care providers, hospitals, infield care centers, and other health care facilities for purposes of my assessment, care and treatment; and/or (2) the Medical Review Officer, , and outside experts, engineers, physicians or consultants retained by any of them, for purposes of safety, quality assurance/improvement, my ability or eligibility to compete, to assist in reviewing accidents and health care services, and making assessments and recommendations related to quality or safety. I understand the Medical Liaison Department coordinators and consulting physicians are not direct treatment providers; they are present at the racetracks to facilitate the sharing of information.

(initial) G. Medical Review Officer Request. I acknowledge that, under the rules of IMSA's Substance Abuse Policy, the Medical Review Officer serves as an independent and impartial physician who investigates whether a laboratory non-negative test result was due to a legitimate medical explanation. I understand that under IMSA rules the Medical Review Officer may request medical information and records as part of inquiring into whether there is a legitimate medical explanation for a result. I specifically request and permit Health Care Providers and the Medical Liaison Department to disclose, discuss and explain my Health Information as necessary to respond to such a request from the Medical Review Officer.

I understand that I have the right to revoke this Authorization in writing at any time by notifying, as applicable, the disclosing Healthcare Provider, Medical Liaison Department, and/or the Medical Review Officer. I understand that the revocation is only effective after it is received. I understand that any use or disclosure made prior to the revocation in reliance on this Authorization will not be affected by a subsequently received revocation.

I understand that once Health Information is disclosed pursuant to this Authorization, it may be re-disclosed by the recipient, and federal or state law might not protect it. I understand a health care provider; hospital or health facility may not condition my treatment on whether this Authorization is signed. I understand that IMSA rules and policies will govern whether I may participate in any IMSA-sanctioned event if I choose to revoke this Authorization.

I have read this Authorization, I understand what it says, and any questions of mine have been answered to my satisfaction. I understand that I am entitled to receive a copy of this Authorization, and I allow a photocopy to be deemed valid as a signed original.

MINOR Competitor Signature: _____ **Date:** _____

PARENT/LEGAL GUARDIAN SIGNATURE: _____ **Date:** _____

2017 IMSA MINOR DRIVER

Consent for Treatment of Minor

This form is required by the International Motor Sports Association, LLC ("IMSA") and its affiliates to ensure that all competitors are able to receive proper medical care while participating in IMSA events and should be returned directly to the Medical Liaison Department prior to the 2017 race season. This consent form will allow relevant medical personnel to facilitate care and/or treatment should your minor child/ward become ill or injured as a result of his or her presence and participation in IMSA events. Due to applicable laws across all states in which IMSA competes, IMSA considers all competitors who are age 18 and under to be minors, but determinations of age of consent for purposes of medical treatment may vary by state.

**To be completed by Parent and/or Legal Guardian
PLEASE TYPE OR PRINT CLEARLY**

Minor's Name: _____	Age: _____	Date of Birth: _____
---------------------	------------	----------------------

As the parent and/or legal guardian of the minor listed above, I hereby consent to the medical treatment/procedures deemed necessary or advisable by the applicable treating physician(s) and medical team as a result of injury or illness arising out of the minor's participation in any event for which the need for medical care arises.

I understand that medical personnel will attempt to contact me to explain the nature and purpose of any necessary treatment, possible alternative methods of treatment, the risks involved, and the possibility of complications. I understand that there is no guarantee or assurance by anyone as to the results that may be obtained. I also understand some emergency situations may arise where I am unavailable and medical personnel are unable to reach me or may not have time to reach me based on emergency needs of the minor, and I consent to any emergency treatment for the minor that may be deemed necessary in the discretion of such treating medical personnel, regardless of whether the nature and purpose of such treatment, possible alternative methods of treatment, the risks involved, and the possibility of complications have been explained to me or not.

I do hereby agree to indemnify and hold harmless any and all treating physicians, and medical personnel, the hospitals and race track care facilities where treatment may occur, the International Motor Sports Association, LLC, and each of their respective parent, subsidiaries, affiliates, employees, and its subsidiaries, agents or representatives who act in reliance upon this authorization.

Parent/Legal Guardian:

Signature: _____ Print Name: _____
Date: _____

Adult Witness:

Signature: _____ Print Name: _____

PARENT AND/OR LEGAL GUARDIAN INFORMATION:

Name: _____ Relationship to Competitor: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Cell Phone: _____ Home Phone: _____ Work Phone: _____

ADDITIONAL PARENT AND/OR LEGAL GUARDIAN INFORMATION:

Is there another parent and/or Legal Guardian of the minor that is legally allowed to make medical decisions for the minor?
 No Yes, and their name is:

Name: _____ Relationship to Minor: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Cell Phone: _____ Home Phone: _____ Work Phone: _____



IMSA Medical Liaison Department
Toni Wright

Senior Medical Liaison Coordinator

Office: (386) 310-6434

Fax: (386) 310-6435

Ashlee Rice

IMSA Medical Administrative Assistant

Office: (386) 310-6438

Fax: (386) 310-6439

Entrants & Drivers:

IMSA requires all drivers to complete a neurocognitive baseline ImPACT test prior to any IMSA-sanctioned on-track activity. The test must be performed within the last two years from date of membership application by a healthcare provider who is a credentialed ImPACT consultant. Please note, if your ImPACT Test expires in the middle of the season, you must complete a new test to continue racing.

Drivers may complete this requirement by going to https://www.impacttest.com/find_care_provider/ to find a provider near you.

The IMSA Medical Liaison Department will accept the ImPACT Test three different ways:

- The 5-page ImPACT Test report that you can obtain from your credentialed ImPACT consultant
- The ImPACT Test Submission form accurately completed by a credentialed ImPACT consultant
- The ImPACT Test Confirmation email that you will receive via the email address you use when you take the ImPACT Test

All medical forms including the ImPACT Test Submission form are available at <http://competitors.imsa.com/credentials-membership-driver-application-forms> or by contacting the IMSA Medical Liaison department.

The IMSA Medical Liaison department collects & retains all ImPACT test documents. After completing the test, a physiatrist (medical physician specializing in rehabilitation medicine) will review the test for validity & accuracy. Any concerns will be reported directly to the competitor.

For information and resources about concussions, visit The Center of Disease Control and Prevention website at <http://www.cdc.gov/headsup/index.html>.

The Medical Liaison Department is here to assist you. Please do not hesitate to contact us.

Sincerely,

Medical Liaison Department
Enclosures



ImPACT TEST SUBMISSION FORM

PLEASE TYPE OR PRINT

Driver Name: _____

Date of Birth: ____/____/____ Age: _____

Cell Phone: _____

ImPACT Test Information

I have attached the most recent ImPACT Test performed on ____ - ____ - 20_____

OR

I have chosen not to provide a copy of my ImPACT Test. It was performed by:

Printed Name of Credentialed ImPACT Consultant Date

Signature of Credentialed ImPACT Consultant Date

Should a copy be necessary for evaluation and/or treatment, a copy will be on file and available within 24 hours per any request from a treating physician, at the following location:

Name

Address

City State Zip
(____)

Phone Weekend Contact Information

Competitor Signature: _____ Date: _____

If you have any questions please contact the IMSA Medical Liaison Department.
IMSA Medical Liaison Department • One Daytona Blvd • Daytona Beach, Florida 32114
Toni Wright – Phone: 386-310-6434 • Fax: 386-310-6435
Ashlee Rice - Phone: 386-310-6438 • Fax: 386-310-6439