

Wrmxc MX

Venue ...

Date

INDEMNIFICATIONS

In consideration for being permitted to participate in this event I declare:

1. That I have read the rules and regulations for the Off Road Promoters Association, the rules and regulations for the club/promoter of this event, the supplementary regulations and entry form (when applicable) and I agree to be bound by them in every respect.
2. That I am fit and not suffering from any physical or mental disability which would impair my safe participation in the meeting and I undertake to inform the organisers immediately should any change in my condition occur which I have reason to or ought to have reason to believe would affect my ability to continue to participate in this competition.
3. That I have completed a medical questionnaire form and that I will inform ORPA and the promoter/organisers of this event, should my medical status have changed.
4. That as a participant I may be exposed to the risk inherent in motor sport and that I am prepared to take such risks.
5. I further agree that I shall not seek to claim against ORPA, the organisers nor their officials, the land owners, the promoter or other bodies or individuals connected with the event in respect of any damage to my property howsoever caused, and whether by the negligence or breach of statutory duty of the said bodies or persons.

Rider's Name:

Address:

..... Post Code:

We need a telephone or email to contact you for event changes and cancellations.

Telephone No: Mobile Tel No:

Machine: Class:

Club: wrmxc Preferred racing No:

Rider's Signature: Date:

Email :-

Parent/Guardian's Signature (if under 18):

MEDICAL QUESTIONNAIRE

To be completed by **ALL** competitors wishing to enter the event overleaf.

Name:

Address:

..... Post Code:

Telephone No:(Home)(Work)

1. Have you ever suffered from the following or any other serious illness?

Polio	YES/NO	Asthma	YES/NO
Pneumonia	YES/NO	Fainting	YES/NO
Meningitis	YES/NO	Epilepsy	YES/NO
Attacks	YES/NO	Tuberculosis	YES/NO
Convulsions	YES/NO	Nerves	YES/NO
Heart/Blood Disorder	YES/NO	Other Illnesses	YES/NO *

* Please give details:

1. Are you suffering from any illness at the moment? YES/NO

If YES please give details:.....

2. Do you have any vision defect? YES/NO

If YES please give details:.....

3. Do you wear spectacles? YES/NO

4. Do you have any condition which affects arm or leg movements? YES/NO

If YES please give details:.....

5. Do you have any false or missing limbs? YES/NO

6. Please give name and address of family doctor:

Doctors Name:

Address:

I certify that the above facts are true to the best of my belief and there is no known medical reason that would debar me from entering the O.R.P.A. event overleaf. *These details are strictly confidential, your doctor will not be contacted without your prior knowledge and in any event only where there may be a medical query.*

Signed: Date: