



**ENTRY FORM**

VENUE: Highway 341  
 Virginia City, NV  
 DATE: June 25-26, 2010

ENTRANT: \_\_\_\_\_ DR. LIC. NO: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 EMAIL: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ PHONE: \_\_\_\_\_

PASSENGER: \_\_\_\_\_ DR. LIC. NO: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 EMAIL: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ PHONE: \_\_\_\_\_

**DESCRIPTION OF CAR**

Make: \_\_\_\_\_ Model: \_\_\_\_\_ Year: \_\_\_\_\_ Color: \_\_\_\_\_

Engine Displacement: \_\_\_\_\_ cid Nitrous – Y/N \_\_\_\_\_ shot  
 Turbocharger - Y/N \_\_\_\_\_ size Supercharger - Y/N \_\_\_\_\_ size

**TIRES**

Brand: \_\_\_\_\_ Size (front): \_\_\_\_\_ Size (rear): \_\_\_\_\_  
 Age of tires: \_\_\_\_\_ Tread Wear Rating: \_\_\_\_\_

Please email completed entry and medical forms to:  
**FM3 Performance Marketing, Inc.**  
 1369 Port Washington Road, Suite 346  
 Grafton, WI 53024  
[spectre341@fm3marketing.com](mailto:spectre341@fm3marketing.com)

Hotel Information:  
[www.spectre341challenge.com](http://www.spectre341challenge.com)

Original or electronic signatures required.

## Vehicle Information

Drivers Name:

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Vehicle Name (if any):

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Vehicle Make and Year:

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Engine Make and Size:

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Induction, Cylinder Heads:

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Horsepower:

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Transmission:

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Exhaust:

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Tires:

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Wheels:

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Brakes:

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Suspension:

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Paint:

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Major Modifications:

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Sponsors:

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The commentators will use the information on this sheet for commentary over the PA system.

Official use only

Car #: \_\_\_\_\_

Completed medical form - Y/N

**DISCLAIMER**  
**EXCLUSION OF LIABILITY, RELEASE AND ASSUMPTION OF RISK**

**REGISTERED OWNER**

*For Registered Owner (legal owner of vehicle)*

I/We being the registered owner/s of the vehicle described on this Entry Form wish to enter that vehicle for the above event.

*For Registered Owner/s and Passengers*

I/We being the registered owner/s and/or passenger, certify that the particulars on this form are true and correct in every particular, to the best of my/our knowledge and belief. I/We declare that I/we have read and understood the Official Rules issued for the event, and agree to be bound by them.

In exchange for being able to attend or participate in the event (including entering the event), I agree:

- To release FM3 Performance Marketing, Inc., Spectre Performance, Speed by Spectre, promoters, sponsor organizations, land owners and lessees, organizers of the event, their respective servants, officials, representatives and agents (collectively, the "Associated Entities") from all liability for my death, personal injury (including burns), psychological trauma, loss or damage (including property damage) ("harm") howsoever arising from my participation in or attendance at the event, except to the extent prohibited by law;
- That the Associated Entities do not make any warranty, implied or express, that the event services will be provided with due care and skill or that any materials provided in connection with the services will be fit for the purpose for which they are supplied; and
- To attend or participate in the event at my own risk.

I/we acknowledge that:

- The risks associated with attending or participating in the event include the risk that I may suffer harm as a result of:
- Motor vehicles (or parts of them) colliding with other motor vehicles, persons or property;
- Acts of violence and other harmful acts (whether intentional or inadvertent) committed by persons attending or participating in the event; and
- The failure or unsuitability of facilities (including grand-stands, fences and guard rails) to ensure the safety of persons or property at the event.
- Motor sport is dangerous and that accidents causing harm can and do happen and may happen to me.

I/we agree that:

- I will be responsible for any damage, property or otherwise, caused by this vehicle entry.

I accept the conditions of, and acknowledge the risks arising from, attending or participating in the event and being provided with the event services by the Associated Entities.

Registered owner's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Passenger's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Official use only

Car #: \_\_\_\_\_

Completed medical form - Y/N

# MEDICAL INFORMATION FORM (DRIVER)

MUST BE COMPLETED BY ALL DRIVERS

Driver Name: \_\_\_\_\_

In the event of an accident the following information is important. Please complete the following:

## HEALTH HISTORY

<b>YES</b>	<b>NO</b>	<b>YES</b>	<b>NO</b>	<b>YES</b>	<b>NO</b>
( )	( ) Asthma	( )	( ) Nervous Stomach	( )	( ) Head or Spinal Injuries
( )	( ) Tuberculosis	( )	( ) Muscular Disease	( )	( ) Extensive confinement
( )	( ) Kidney Disease	( )	( ) Rheumatic Fever	( )	( ) Seizures, fits, convulsions or fainting
( )	( ) Psychiatric Disorder	( )	( ) Any other nervous disorder	( )	( ) Diabetes
( )	( ) Cardiovascular Disease	( )	( ) Suffering from any other disease	( )	( ) Gastrointestinal ulcer
( )	( ) Permanent defect from illness, disease				

If the answer to any of the above is YES, explain: \_\_\_\_\_

**PARTICIPANT:** Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Blood Type: \_\_\_\_\_ Drug Sensitivities: \_\_\_\_\_

	<u>NORMAL</u>	<u>ABNORMAL</u>		<u>NORMAL</u>	<u>ABNORMAL</u>
Vision	_____	_____	Heart Condition	_____	_____
Hearing	_____	_____	Lungs & Chest	_____	_____
Extremities	_____	_____	General Systemic	_____	_____
Neurological	_____	_____			

Comments: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_ Medical Alerts: \_\_\_\_\_

Current Medications: \_\_\_\_\_ Other: \_\_\_\_\_

Name of Personal Physician (Please Type or Print) \_\_\_\_\_ Phone Number \_\_\_\_\_

**In the event of an emergency, contact:** \_\_\_\_\_

Name (Type or Print Legibly) Relationship Phone Number

I **do** \_\_\_ give permission to release my medical information/physical form to emergency personnel.

I **do not** \_\_\_ give permission to release my medical information/physical form to emergency personnel.

**I attest that I have current Medical Insurance Coverage.**

Driver Signature \_\_\_\_\_ Date \_\_\_\_\_

Official use only

Car #: \_\_\_\_\_

Completed medical form - Y/N

# MEDICAL INFORMATION FORM (PASSENGER)

MUST BE COMPLETED BY ALL Passengers

Passenger Name: \_\_\_\_\_

In the event of an accident the following information is important. Please complete the following:

## HEALTH HISTORY

<b>YES</b>	<b>NO</b>	<b>YES</b>	<b>NO</b>	<b>YES</b>	<b>NO</b>
( )	( ) Asthma	( )	( ) Nervous Stomach	( )	( ) Head or Spinal Injuries
( )	( ) Tuberculosis	( )	( ) Muscular Disease	( )	( ) Extensive confinement
( )	( ) Kidney Disease	( )	( ) Rheumatic Fever	( )	( ) Seizures, fits, convulsions or fainting
( )	( ) Psychiatric Disorder	( )	( ) Any other nervous disorder	( )	( ) Diabetes
( )	( ) Cardiovascular Disease	( )	( ) Suffering from any other disease	( )	( ) Gastrointestinal ulcer
( )	( ) Permanent defect from illness, disease				

If the answer to any of the above is YES, explain: \_\_\_\_\_

**PARTICIPANT:** Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Blood Type: \_\_\_\_\_ Drug Sensitivities: \_\_\_\_\_

	<u>NORMAL</u>	<u>ABNORMAL</u>		<u>NORMAL</u>	<u>ABNORMAL</u>
Vision	_____	_____	Heart Condition	_____	_____
Hearing	_____	_____	Lungs & Chest	_____	_____
Extremities	_____	_____	General Systemic	_____	_____
Neurological	_____	_____			

Comments: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_ Medical Alerts: \_\_\_\_\_

Current Medications: \_\_\_\_\_ Other: \_\_\_\_\_

Name of Personal Physician (Please Type or Print) \_\_\_\_\_ Phone Number \_\_\_\_\_

**In the event of an emergency, contact:** \_\_\_\_\_

Name (Type or Print Legibly) \_\_\_\_\_ Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

I do \_\_\_ give permission to release my medical information/physical form to emergency personnel.

I do not \_\_\_ give permission to release my medical information/physical form to emergency personnel.

**I attest that I have current Medical Insurance Coverage.**

Passenger Signature \_\_\_\_\_

Date \_\_\_\_\_

Official use only

Car #: \_\_\_\_\_

Completed medical form - Y/N

Official use only

Car #: \_\_\_\_\_

Completed medical form - Y/N