PHYSICAL EXAMINATION FORM FOR A COMPETITION LICENSEE

(To be filled out on both sides examining physician and returned to candidate.)

Dear Doctor: You are being asked to examine this candidate who wishes to take part in motor racing events in which it will be possible for him/her to drive a competition car at extremely high speeds under most exacting conditions. Please, therefore, examine carefully and critically, and recommend him/her only if you are completely satisfied in all respects. An appeal procedure exist whereby he/she may take the matter up with physicians experienced in racing should you disapprove him/her. You will thus be doing not only the applicant but our sport and yourself a service by conducting this examination as carefully as possible.

ALL CANDIDATES AGE 40 AND OVER MUST HAVE AN EKG AS PART OF THE EXAMINATION.

Candidates having the following afflictions must be reviewed:

1. Diabetes
2. Epilepsy
3 Spasmodic
4. Loss of color vision
5. History of Heart Attack
6. Loss of extremity or eye
7. Psychological problems
8. Alcohol or drug addiction
9. All gross deformities subject to listing
10. Less than 20/30 corrected vision in the better eye
11. Blood pressure: Diastolic over 100, systolic over 170

Name:_____ Age:_____ Birthdate:_____

Street Address:_____ City/State/Zip:_____

Sex		Height		Weight		Color of Hair		Color of Eyes	

Normal	Check each item in appropriate column (enter NE if not evaluated)	Abnormal	25. DISTANT VISION
	1. Head, face, neck and scald		Right eye – 20/ Corrected to 20/
	2. Nose		Left eye – 20/ Corrected to 20/
	3. Sinuses		Both eyes – 20/ Corrected to 20/
	4. Mouth and throat		26. &27. Intraocular Tension: TACTILE
	5. Ears, general		Right eye
	6. Drums (perforation)		Left eye
	7. Eyes, general (visual acuity under item 25)		28. FIELD OF VISION
	8. Ophthalmoscopic		Right eye
	9. Pupils		Left eye
	10. Ocular Mobility (associated parallel movement, nystagmus)		29. Color vision
	11. Lungs and chest (including breast)		30. BLOOD PRESSURE
	12. Heart size (thrust, size, rhythm, sounds)		
	13. Vascular system		Systolic
	14. Abdomen and viscera (including hemia)		Diastolic
	15. Anus and rectum		31. PULSE Resting
	16. Endocrine system		After exercise
	17. G-U system		2 minutes after exercise
	18. Upper and lower extremities (strength and range of motion)		32. URINALYSIS
	19. Spine, other musculosketal		Albumin
	20. Identifying body marks, scars, tattoos		Sugar
	21. Skin and lymphatics		33. othertests
	22. Neurologic (tendon reflexes, equilibrium, senses, coordination, etc.)		
	23. Psychiatric (specify and personality deviation)		34. EKG results (40 and over)
	24. General systemic		Normal Abnormal

35. Medical treatment within the past 5 years: Date_____ Name and address of physician consulted_____

Reason_____

_____

36. COMMENTS ON HISTORY AND FINDINGS: _____

RE-EXAMINATION: It shall be the responsibility of the applicant to present himself for re-examination as follows:

1. Upon the expiration of his current medical examination form as required by the GCR.
2. Following any significant illness, injury or hospitalization.

REMARKS: _____

The applicant should have no established medical history or clinical diagnosis that may reasonably be expected, within one (1) year after finding, to make him/her unable to perform the duties as described above. On the basis of the above information, and mindful of the note addressed to me, I make the following recommendation:

- ☐ That the applicant is physically and psychologically fit to drive a racing car in competitive events at high speeds.
- ☐ That the applicant be reviewed by the Medical Committee.
- ☐ That the applicant is NOT physically and/or psychologically fit to drive a racing car in competitive events at high speeds. **CANDIDATES WHO HAVE HAD A MYOCARDIAL INFRACTION, WHO ARE DIABETIC AND TAKE INSULIN, OR WHO HAVE ANY OF THE 11 CONDITIONS LISTED ABOVE MUST BE REFERRED TO THE MEDICAL REPRESENTATIVE.**

Signed:_____(examining physician) Date: _____ Address_____

Applicant's Medical History

Name_____ Age_____ Date of Birth_____ Sex_____

Street Address_____City/State/Zip_____

☐ Single ☐ Married ☐ Widowed ☐ Divorced

Your Personal Physician_____Address_____

Examining Physician (today)_____Address_____

A. Have you been treated for, have you ever had, or have you now any of the following? (For each "yes" checked, describe or explain below or on a separate sheet.)

YES		NO
_____	1. Frequent or severe headaches	_____
_____	2. Dizziness or fainting spells	_____
_____	3. Unconsciousness for any reason	_____
_____	4. Eye trouble, except glasses	_____
_____	5. Hay fever	_____
_____	6. Asthma	_____
_____	7. Allergy to medications or other drugs in addition to hay fever and asthma	_____
_____	8. Diabetes-insulin and how much	_____
_____	9. Heart trouble	_____
_____	10. High or low blood pressure	_____
_____	11. Anemia or other blood diseases, including abnormal bleeding	_____
_____	12. Stomach trouble	_____
_____	13. Kidney stone or blood urine	_____
_____	14. Sugar or albumin in urine	_____
_____	15. Epilepsy or fits	_____
_____	16. Nervous trouble of any sort	_____
_____	17. Any mental trouble	_____
_____	18. Any drug or narcotic habit	_____
_____	19. Excessive drinking habit	_____
_____	20. Attempted suicide	_____
_____	21. Motion sickness requiring drugs	_____
_____	22. Admission to hospital within the last 12 months	_____
_____	23. Operations involving eyes, brain, heart, nerves or blood vessels	_____
_____	24. Amputation or physical disability	_____
_____	25. Other illness	_____
_____	26. Immunization against tetanus (y toxoid) – list date below	_____
_____	27. Tetanus boosters – list dates below	_____
_____	28. Rejection for life insurance	_____
_____	29. Medical rejection from or for military service	_____
_____	30. Military medical discharge	_____
_____	31. Disability compensation from the Veterans Administration, compensation insurance company, or any government agency.	_____

REMARKS: _____

_____

_____

B. List any medication currently used (including eye drops).

C. Have you had an automobile accident, including racing, in the past two (2) years? If yes, explain or describe. _____

_____

This is to certify that the above statements are true and accurate. I also give permission to any hospital, institution or physician to furnish any information relative to my condition.

APPLICANTS SIGNATURE:_____DATE:_____

WITNESS SIGNATURE:_____DATE:_____

(Examining Physician)