



# Examination and Medical History Forms

***Please Keep a Copy***

***Reverse side of form to be completed by examiner (MD, DO, PA-C or NP) and returned to the applicant. Any blanks will delay processing of the license!***

## **Memorandum to Examining Physician:**

You are being asked to examine this applicant for the purpose of obtaining an automobile racing license. This form is a guide and tool for you to determine if the applicant is medically qualified to race. This form concentrates on the organ system and disease processes that may jeopardize the applicant or others while attending a competitive racing event.

**Page One** (this page) - Instructions for completing the Physical Examination form, and should be read carefully by both the examining physician and the applicant.

**Examination** is to be completed by a Physician.

**Medical History** is to be completed by the applicant.

### **A. The functional suggested requirements of a driver in a competition automobile are:**

1. Ability to rapidly operate acceleration, braking, and steering mechanisms/systems.
2. Vision: distant vision correctable to 20/40 each eye, ability to distinguish basic colors, and peripheral vision to 70 degrees in the horizontal median for each eye.
3. Should have minimal chance of sudden incapacitation from any disease process.
4. Ability for rapid mental activity, problem solving, and decision-making.
5. Ability to maintain an aerobic level heart rate for more than 20 minutes.

### **B. The environment this applicant may operate in is:**

1. Temperature extremes from 0 degrees (F) to 120 degrees (F) for long periods of time.
2. Smoke, fumes, vapor, caustic chemicals, and dust.
3. Loud noise and vibration.
4. Increased potential for exposure to fire.

**Special Cases:** In a case where consults are needed, the consultant should be made aware of the information in **Section A** and **Section B** of this memorandum.

**Requirement of All Applicants\*:** All applicants must submit a completed APPLICANT'S MEDICAL HISTORY and PHYSICIAN'S EXAM. Similar forms from NASA or full FAA may be acceptable. However, the applicant will be held accountable to the rules, laws, and other parameters, as set forth by the issuing organization or agency.

### **Renewals:**

Applicants that are less than 40 years old must renew their Physical Examination every five years.

Applicants that are at least 40 years old must renew their Physical Examination every three years.

Applicants that are at least 50 years old must renew their Physical Examination every two years.

Applicants that are at least 70 years old must renew their Physical every 12 months.

**Note to the examining physician:** Please note the "**Renewals**" section of this document (above). Consideration should be given to the length of time between examinations, unless otherwise specified with highlighted notation in the comment section found on the PHYSICIAN'S EXAMINATION page of this document.

**Note to Physician and Applicant: Medical Fitness of a Driver-Changes in Medical Condition after approved physical. Refer to GCR 2.3.2.A.3.**

# Examination

To be completed by a MD, DO, PA-C or NP only. Any blanks will delay processing!

Examination shall not be more than six (6) months old upon license application.

There are Four PAGES to this form. Please see "APPLICANT'S MEDICAL HISTORY" and "SCCA Competition License Physical Examination Instructions." Use the fourth page for any explanations.

Applicant's Name: \_\_\_\_\_ Date: \_\_\_\_\_ Member #: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Eye Color: \_\_\_\_\_

Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_ Respiration: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

## NEUROLOGICAL

Reflexes: \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal

Other tests performed: \_\_\_\_\_

## CARDIAC

Cardiac Exam: \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal

## METABOLIC *if yes then HgbA1C level recommended*

History of diabetes: \_\_\_\_\_ No \_\_\_\_\_ Yes

HgbA1C (less than 10) \_\_\_\_\_

## VISION

Vision (use numbers 20/20) OD (Right) : \_\_\_\_\_ / \_\_\_\_\_ OS (Left): \_\_\_\_\_ / \_\_\_\_\_ OU (Both): \_\_\_\_\_ / \_\_\_\_\_

Color Vision: \_\_\_\_\_ Test: \_\_\_\_\_

Peripheral Vision (use numbers) degrees from midline: \_\_\_\_\_ OD: \_\_\_\_\_ OS: \_\_\_\_\_ Test: \_\_\_\_\_

## Medical conditions to consider in the decision to approve candidate

- |   |   |   |
|---|---|---|
| 1. Less than 20/40 corrected vision in the better eye   | 7. Diabetes   | 12. Epilepsy  |
| 2. Alcoholic or drug addiction                          | 8. Loss of consciousness  | 13. History of Heart Attack   |
| 3. Blood pressure: Diastolic over 90, systolic over 160 | 9. Psychological problems   | 14. History of Cardiac Disease  |
| 4. All gross deformities subject to listing             | 10. Implanted Defibrillator   | 15. Use of Narcotics  |
| 5. History of Syncope                                   | 11. Limitations of endurance in any activities of daily living (i.e. climbing 2-3 flights of stairs without stopping) | 16. Reduced pulmonary capacity (includes the need for supplemental oxygen.) |
| 6. Loss of extremity or eyes                            |   |   |

## **RACING is a physically demanding sport.**

The environment frequently involves high temperatures with a limited ability to cool and requires long periods of aerobic exertion. If the applicant experiences any physical or medical limitations that would potentially affect their ability to tolerate the demands of racing, approval should not be given.

**Please contact SCCA with any questions at 1-800-770-2055**

## **APPROVED**

**Medical history and examination approved**

**Applicant is fit for motor racing**

**Additional review may apply for FIA applicants**

Physician's Signature \_\_\_\_\_

Printed Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Date \_\_\_\_\_

## **FAILED**

**Applicant is not fit for motor racing**

Physician's Signature \_\_\_\_\_

Printed Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Date \_\_\_\_\_



# Applicant's Medical History

(To be completed by Applicant)

Applicant: For the purpose of obtaining a SCCA Competition License, complete this page legibly and in its entirety. Failure to complete the information will delay processing of your license. The examining physician must complete the second page of this form.

Member # \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City, St, Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Personal Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City, St, Zip: \_\_\_\_\_

**PLEASE INDICATE IF YOU EVER HAD, OR HAVE NOW, ANY OF THE FOLLOWING:**

Do You Have or Have You Ever Had?	Yes	No	Do You Have or Have You Ever Had?	Yes	No
Frequent or severe headaches			Any drug, narcotic, or alcohol problems		
Unconsciousness for any reason			Psychiatric/mental health problems		
Dizziness or fainting spells			Eye trouble (except glasses)		
Epilepsy or seizures			Asthma		
Coronary artery disease or angina			Diabetes requiring insulin		
Heart valve disease			Anemia or other blood diseases Including abnormal bleeding		
Left Bundle Branch Block (heart)			Admission to a hospital in the past 12 months for any reason		
Abnormal cardiac rhythms			Allergy(s) to medications List:		
High Blood pressure			Routine use of Pain Medication		
Operation(s) on brain			Amputations/physical disability		
Operation(s) on heart			Illness(es) not listed above List:		
Operation(s) on eyes, nerves, blood Vessels, or bone			Do you require the use of supplemental oxygen or other external breathing device?		
Previous waiver(s) from SCCA, NASA, or other sanctioning body for medical condition(s) list:			Previous denial(s) from SCCA, NASA, or other sanctioning body due to Medical reasons		

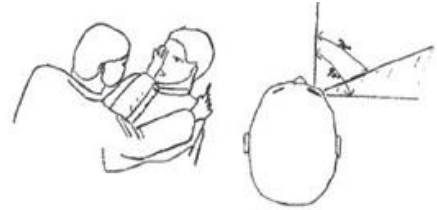
**Blood Thinner Medication (circle) YES NO**

Comments and details of any condition noted above (Use the fourth page for any explanations that do not fit here) Medication Used (including eye drops) \_\_\_\_\_

Members Signature \_\_\_\_\_ Date \_\_\_\_\_

**Tips on Peripheral Vision Exam:**

Peripheral vision exam by confrontation is simple procedure. Position yourself so that your face is directly in front and on the same level with the patient, about 2 feet away. Ask the patient to cover one eye and to look at your eye directly opposite. Close your other eye so that your own visual field is roughly superimposed on that of the patient. Bring a pencil or other small object (light) from behind and from the periphery slowly into the patient's field of vision. Ask the patient to indicate when the object appears. Estimate in degrees the point where the patient sees the object to the point where the patient is looking directly ahead. Test the other eye in the same manner. Lack of adequate or impaired peripheral vision should be given special consideration.



**Additional History or Comments:** \_\_\_\_\_  
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