

APPLICANT'S MEDICAL HISTORY

(To be completed by applicant)

Applicant: For the purpose of obtaining a Competition License, complete this page legibly and in its entirety.

Failure to complete required information will delay the processing of your license.

Examining Physician must complete the reverse side of this form.

Name: _____ Age: _____ Date of Birth: _____

Address: _____ City, St. Zip: _____

Phone: (H) _____ (C) _____ E-mail _____

Occupation: _____ Sex: _____ Martial Status: _____ Years as licensed racer: _____

Your Personal Physician: _____ Phone: _____

Address: _____ City, St. Zip: _____

Examining Physician : _____ Phone: _____

Address: _____ City, St. Zip: _____

A. Have you been treated for, have you ever had, or have you now, any of the following:

(Yes responses should be explained: separate sheet may be attached)

Conditions	Yes	No
Frequent or severe headaches		
Unconsciousness for any reason		
Dizziness or fainting spells		
Epilepsy or Seizures		
Heart Trouble: Coronary Artery Disease or Angina Valve disease Left Bundle Branch Block Abnormal Cardiac Rhythms		
High Blood Pressure		
Any drug, narcotic or alcohol problems		
Psychiatric/Mental Health Problems		
Operation(s) involving Eyes, Brain, Heart, Nerves, Blood Vessels, or Bones		
Previous waiver(s) for a medical condition: List:		

Conditions	Yes	No
Hay fever		
Eye trouble (except glasses)		
Asthma		
Diabetes		
Anemia, or other blood diseases including abnormal bleeding		
Admission to a hospital in the past 12 months		
Allergy(s) to medications List:		
Amputations /Physical disability		
Previous denial(s due to a medical reason(s) List:		
Illness not mentioned above List:		

Date of last Tetanus: _____ Blood Type (if known): _____

Comments: _____

Medications Used (including eye drops): _____

This is to certify that these statements are true and accurate.

Applicant's Signature: _____ **Date:** _____

PHYSICIAN'S EXAMINATION To be completed by an MD, DO, PA-C or NP only

Applicant's Name: _____ Age: _____ Sex: _____ Height: _____

Weight: _____ Hair Color: _____ Eye Color: _____

**NOTE: VINTAGE RACING is a very physically demanding sport.
Please perform your examination and recommendation with that in mind.**

Blood Pressure: _____ Pulse: _____ Respiration: _____
Abnormalities of the above or any of the following conditions should be cause for concern and consideration by the examining physician:

- Less than 20/40 corrected vision in the better eye
- Alcoholic or drug addiction
- Blood pressure: Diastolic over 90, systolic over 160
- All gross deformities subject to listing
- Loss of extremity or eye
- Diabetes
- Loss of color vision
- Psychological problems
- Epilepsy
- History of Heart Attack

VISION

Vision OD: _____ OS: _____ OU: _____

Color Vision: _____ Test: _____

Peripheral Vision (degrees from midline): _____ OD: _____ OS: _____ Test: _____

NEUROLOGICAL

Reflexes: _____ Normal _____ Abnormal Cerebellar: _____ Normal _____ Abnormal

Other tests performed: _____

CARDIAC

At the age of 40, a baseline EKG should be performed. Further EKG's need to be completed only if the candidate is a smoker, has a cardiac history, a strong family history of cardiac disease, history of diabetes, or has hypertension (sys-tolic > 140, diastolic > 90). Cardiac Exam: _____ Normal _____ Abnormal

METABOLIC

History of Diabetes: _____ Yes _____ No HgbA1C (less than 10) _____

Comments regarding current medications the applicant is taking (i.e. any side effects): _____

Examining Physician's Comments regarding applicant's medical history: _____

Please check: this form is not valid without this section completed.

On the basis of this limited examination, review of the patient's history, and the instructions addressed to me, I
_____ *find the candidate medically acceptable to operate a high speed competition automobile.*

Signed: _____ **Date:** _____

Printed Name: _____ Phone: _____

Address: _____ City, St. Zip: _____