



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:

The three pages of this form are collectively referred to as the "Physical Examination." You are being asked to examine this applicant for the purpose of obtaining an automobile racing license. This form concentrates on the organ system and disease processes that may jeopardize the applicant or others while attending a competitive racing event. If you deem that the applicant may be in questionable condition, the matter may be turned over to the SCCA Medical Directory for review.

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

Page Two is to be completed by the applicant.

Page Three is to be completed by a Physician.

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.

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 other recognized organization and agencies 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 60 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.

***Exceptions:** Medical Waivers may be granted in certain circumstances with the approval of the proper authorities, as listed on the Application for a Medical Waiver form. Drivers that have been granted a Medical Waiver may be subject to special requirements as the SCCA Medical Director and Medical Review Board stipulate.

Examination

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

Examination shall not be more than three (3) months old upon license application.

Note- 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: _____

IMPORTANT NOTES: Candidates having the following afflictions must be referred to the SCCA Medical Board for review:

- | | | |
|---|-----------------------------|--------------------------------|
| 1. Less than 20/40 corrected vision in the better eye | 6. Loss of extremity or eye | 11. Epilepsy |
| 2. Alcoholic or drug addiction | 7. Diabetes | 12. History of Heart Attack |
| 3. Blood pressure: Diastolic over 90, systolic over 160 | 8. Loss of color vision | 13. History of Cardiac Disease |
| 4. All gross deformities subject to listing | 9. Psychological problems | 14. Loss of consciousness |
| 5. History of Syncope | 10. Implanted Defibrillator | |

Abnormalities require an attached Vision-ophthalmological, Neurological or Cardiac consult.

Blood Pressure: _____ **Pulse:** _____ **Respiration:** _____ **Weight:** _____ **Height:** _____

NEUROLOGICAL Abnormalities require neurological consult

Reflexes: ___ Normal ___ Abnormal

Other tests performed: _____

CARDIAC Abnormalities require cardiological consult

Cardiac Exam: ___ Normal ___ Abnormal

METABOLIC Please attach an HgbA1C and Endocrinologic consult for any history of diabetes.

History of diabetes : ___ No ___ Yes

HgbA1C (less than 10) _____

VISION Abnormalities refer to above

Vision (use numbers) OD: _____ OS: _____ OU: _____

Color Vision: _____ Test: _____

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

Comments or concerns regarding past or present health, review of APPLICANT'S MEDICAL HISTORY, and the instructions addressed to me, I conclude the following:

RACING is a very physically demanding sport.

Please perform your examination and recommendation with that in mind.

Recommend Approval

I believe applicant is fit for motor racing

Signature _____

Printed Name _____

Address _____

City _____ State _____ Zip _____

Phone Number _____

FAIL or REVIEW

Applicant should be referred for Medical Review

Signature _____

Printed Name _____

Address _____

City _____ State _____ Zip _____

Phone Number _____



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. Note- the answer of "yes" for any condition highlighted below may be cause for review by the SCCA Medical Director.

Member # _____

Name: _____ Age: _____ Date of Birth: _____

Address: _____ City, St, Zip: _____

Email Address: _____ Occupation: _____

Phone: (H) _____ (W) _____ (C) _____

Personal Physician: _____ Phone: _____

Address: _____ City, St, Zip: _____

Examining 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
Frequent or severe headaches		
Unconsciousness for any reason		
Dizziness or fainting spells		
Epilepsy or seizures		
Coronary artery disease or angina		
Heart valve disease		
Left Bundle Branch Block (heart)		
Abnormal cardiac rhythms		
High Blood pressure		
Operation(s) on brain		
Operation(s) on heart		
Operation(s) on eyes, nerves, blood vessels, or bone		
Previous waiver(s) from SCCA, NASA, or other sanctioning body for medical condition(s) list:		

Do You Have or Have You Ever Had?	Yes	No
Any drug, narcotic, or alcohol problems		
Psychiatric/mental health problems		
Eye trouble (except glasses)		
Asthma		
Diabetes requiring insulin		
Anemia or other blood diseases including abnormal bleeding		
Admission to a hospital in the past 12 months for any reason		
Allergy(s) to medications List:		
Routine use of Pain Medication		
Amputations/physical disability		
Illness(es) not listed above List:		
Previous denial(s) from SCCA, NASA, or other sanctioning body due to medical reasons List:		

Date of last Tetanus _____ Blood Type _____ **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)

Medications Used (including eye drops) _____

I certify that the above is true and correct information. I also give my permission for the SCCA administration to access and/or exchange information with health care providers as well as the medical administration of other sanctioning bodies.

Applicant's Signature _____ Date _____

