CORINTHIAN VINTAGE AUTO RACING

National Competition License Medical Form

Dear Doctor,
You are being asked to examine this applicant for the purpose of obtaining racing privileges. This form concentrates on conditions and disease processes that could lead to injury or even death of the applicant during high speed driving at a racing event and possibly put others at risk who are participating in such event.
From a physical point of view, a driver must have:

1. **musculoskeletal integrity** - the physical ability to operate the mechanical systems of the race car in a rapid manner (assist devices allowed on case by case basis).
2. **good vision** - distant vision correctable to 20/30 in each eye, normal depth perception, ability to distinguish basic colors (red, green, yellow, blue and black flags are used to signal drivers when on the course), a peripheral vision to 70 degrees in the horizontal median for each eye.
3. **good general health** - minimal chance of sudden incapacitation from any disease or from drug therapy foe ongoing treatment of stable chronic disease.
4. **mental acuity** - the ability for rapid mental activity and problem solving.

The applicant must be able to operate a race car in an environment which may contain:

1. **high heat** (temperatures in race cars may exceed 20 degrees over ambient).
2. **presence of fumes, noxious vapors**, and **dust**
3. v**ery loud noise levels, high "G forces**" and **vibration**.
4. **risk** of **collision, flying debris** and **fire.**

With the above listed requirements and conditions in mind special consideration should be given by the physician to the candidate who has any of the following:

loss of extremity or eye	alcohol or drug addition	diabetes
high blood pressure	psychological problems	asthma
cardiac disease	neurological problems	epilepsy
ongoing drug therapy	stroke hx. with sequela	COPD

Frequency of examinations:

Applicants are required to have a medical examination:

- **every three (3) years for those 16-35 years of age**
- **every two (2) years for those 36-59 years of age**
- **each year starting at age 60**

Applicants Medical History

(to be filled out by candidate)

Applicant_________________________ Spouse_________________

Address____

Phone (day)______________(night)______________Birthdate____/____/__________

Occupation____

Have you been treated for, ever had, or have you now, any of the following?

(For each "YES" checked, describe or explain below or on the back of this sheet.)

Yes	Condition or disease	No
	1. Frequent or severe headaches, dizziness or fainting spells	
	2. Epilepsy or stroke, unconsciousness for any reason	
	3. Eye problems (not including glasses), color blindness	
	4. Asthma or other breathing problems, shortness of breath, lung disease	
	5. Diabetes, requiring medication	
	6. Heart attack, angina, heart failure, irregular heart beat	
	7. High or low blood pressure	
	8. Anemia or other blood diseases, tendency to bleed	
	9. Psychiatric or mental health problems	
	10. Hospital stay in the last 12 months	
	11. Operations involving eyes, brain, heart, nerves or blood vessels	
	12. Allergy to medications	
	13. Amputation or physical disability	
	14. Alcoholism or drug abuse	
	15. Family history of cardiac death at < 60 years old	

Date of last Tetanus__________________Blood Type (if known)________________

Remarks: Use back of page if necessary_________________________________

____

Medicines currently used (including eye drops)____________________________

I certify all of the statements are true and accurate. I authorize any hospital, institution or physician permission to release medical information which might have bearing on my ability to drive a vintage race in a competitive events. I also agree to notify the organization holding this medical form of any changes which occur during the life of this medical certification which might affect my ability to safely race a car at speed.

Signed:___________________________ **Date:**________________

Examination

To be completed by a MD, DO, MA-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 ***THREE PAGES*** *to this form. Please see "APPLICANT"S MEDICAL HISTORY" and "Competition License Physical Examination Instructions" Use back of page for any explanations.*

Applicants Name:____**Date:**_____________

Age:__________**Sex:** ____________

IMPORTANT NOTES: Candidates having the following afflictions requires management status documentation on back of page

1. Less than 20/40 corrected vision in the better eye
2. Alcoholic or drug addiction
3. Blood Pressure: Diastolic over 90, systolic over 160
4. History of Syncope
5. Loss of extremity or eye
6. Diabetes
7. Loss of color vision
8. Psychological problems
9. Implanted Defibrillator
10. Epilepsy
11. History of Heart Attack
12. History of Cardiac Disease
13. Family history of cardiac Death <60 yr.

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

Blood Pressure:_______________**Pulse:**________________**Weight:**_________

NEUROLOGICAL: *Abnormalities require Specialty Consult*
Reflexes:__________ normal ________ abnormal
Hearing:___________ normal _________ abnormal
Pupils: *equal reaction to light & accommodative*
_____________ normal ___________ abnormal

CARDIAC: *Abnormalities require Cardiology Consult*
Cardiac Exam:_______ normal ________abnormal

METABOLIC: (attach Hgb A1C & Int. Med. Consult)
Diabetes on meds _______ no ________ yes
HGB A1C (<9)_____________

EYES: *Abnormalities refer to above*
Vision: OD_________OS ___________OU___________
Color Vision: ________________Test Used:____________
Peripheral Vision (degree from midline) OD_________OS_______
Optic Fundus ________ normal ________ abnormal

EXTREMITIES: *Strength, ROM*
_________ normal _________ abnormal

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

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

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 Speciality Consult
Signature___________________________________
Printed Name________________________________
Address_____________________________________
City________________State________Zip________
Phone Number____________________________