# UNITED STATES AUTO CLUB

## Medical Examination Form
## FIA Competition License

**Exam Date:** ____________

**Last Name** ______________________________ **First Name** ________________________

**Home Address:** ______________________________________________________________

**City:** ______________________________ **State:** ____________ **Zip:** ____________

**Cell Phone:** ________________________ **Work Phone:** ______________________________

**Birth Date:** __________________ **Email Address:** ______________________________

**Height:** ____________ **Weight:** ____________ **Blood Type:** ____________

**Last Tetanus:** ________________________

***APPLICANT'S MEDICAL HISTORY***

**Do you have or have you ever had: (Circle Y or N)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Amnesia | Y or N | Arthritis | Y or N | Asthma | Y or N | Alcohol Abuse | Y or N |
| Dizziness | Y or N | Epilepsy | Y or N | Fainting | Y or N | Emotional Illness | Y or N |
| Hay Fever | Y or N | Hernia | Y or N | Kidney Disease | Y or N | Hypoglycemia | Y or N |
| Migraine | Y or N | Sinusitis | Y or N | Syphilis | Y or N | Vertigo | Y or N |

**Major Injuries:** ____________________________________________________________

**Major Surgeries:** ____________________________________________________________

**Hospitalization within last year:** Y or N **When:** ____________ **Where:** __________________

**Diagnoses:** ________________________________________________________________

**Current Medications:** ________________________________________________________

**Current Medical Conditions:** __________________________________________________

**Other Restrictive Conditions:** _________________________________________________

**History of Diabetes:**____________________________**HgbA1C (less than 10):**________________________

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

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.All gross deformities subject to listing
5.History of Syncope
6.Loss of extremity or eyes
7.Diabetes
8.Loss of consciousness
9.Psychological problems
10.Implanted Defibrillator
11.Limitations of endurance in any activities of daily living (i.e. climbing 2-3 flights of stairs without stopping)
12.Epilepsy
13.History of Heart Attack
14.History of Cardiac Disease
15.Use of Narcotics
16.Reduced pulmonary capacity (includes the need for supplementaloxygen.)

Patient Name: ____________________

## PHYSICAL EXAM

Ears/Hearing ____________________ Nose: ____________________

Abdomen: ____________________ Extremities: ____________________

Blood Pressure: ____/____ Pulse ____________ Respirations: ____________

Resp System (Describe): ____________________

Cardiac (Cond & Size) ____________________ Rhythm/Sound ____________________

EKG (if over 40 y/o): ____________________ Reflex/Neuro: ____________________

## EYE EXAM

| LEFT EYE | RIGHT EYE |
|---|---|
| Vision **Without** glasses/Contacts 20/____ | Vision **Without** glasses/Contacts 20/____ |
| Vision **With** glasses/Contacts 20/____ | Vision **With** glasses/Contacts 20/____ |
| Peripheral Vision: OD OS Test | Peripheral Vision: OD OS Test |
| Color Vision: ____________ | Color Vision: ____________ |

I certify that the above information is correct and that I am physically and psychologically fit to drive a race car and/or a land speed record car at high speeds. Furthermore, I give permission to any health care facility or physician to release all information regarding recent injury or illness to the undersigned physician and/or medical director.

I understand that it is my responsibility to submit to a reexamination yearly and following any significant illness, injury or hospitalization. In addition, *it is* my responsibility to forward, or have forwarded all medical records from physicians and/or hospitals to the medical director.

Applicants Signature ____________________ Date ____________

The applicant is medically fit to drive in competition at high speeds and is recommended for a license with the following restrictions:

**Vision Correction Required** Y or N

**Other Restrictions:** ____________________

**Physician Signature:** ____________________ Date ____________

**Address:** ____________________

**City:** ____________________ **State:** ____________ **Zip:** ____________