



SCCA MEDICAL EXAMINATION PACKET

Includes:

- Declaration of Medical Fitness
- Physician Evaluation Form
- Physician Examination Form (FIA Only)
- Applicant Medical History (FIA Only)
- Additional Comments/Explanation Form (FIA Only)

For use by Competition License, Novice Permit, Vintage and FIA License Applicants.

*You must be 18 years of age, or the age of majority in your state of residence to complete this declaration. Required annually.
This declaration is available in the SCCA Member Account Portal. Online submission is preferred; submit either online or by paper.*



DECLARATION OF MEDICAL FITNESS

SCCA Road Racing competition is physically and mentally demanding, requiring drivers to perform at high speeds for extended periods of time. The following requirements are a guide for you to determine if you are medically fit to participate in a Road Racing event. Failure to handle the stress of automobile competition may jeopardize you or others.

You must be able to handle the physical and mental demands outlined below for the length of each session of an event. These requirements/descriptions should be read carefully before proceeding. If you are unsure whether you can safely meet these requirements, consider consulting a physician before participating.

The suggested functional 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. Must 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.

The environment you 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.

I understand that participation as a crew, worker, official, driver or any other capacity in motorsports is dangerous. Known or unknown conditions and situations involving myself or others, including but not limited to vehicle preparation, equipment condition, facility and environment, physical fitness, medical conditions, medications, knowledge, abilities, or skill can cause injury (significant or otherwise) and death. I understand that I cannot participate in the event if I am on medication, or have a medical condition, that impacts my ability to participate. My decision to enter an event in any capacity, and to continue my participation throughout the event, is voluntary and with the knowledge of the above conditions and potential outcomes.

☐ **I have read the Declaration of Medical Fitness above and declare that I am medically fit to participate.**

Name (Print): _____ Member Number: _____

Name (Sign): _____ Date: _____

Submit online at my.scca.com from My Profile (My Documents), during license purchase or renewal.

THIS PAGE MUST BE COMPLETED AND SUBMITTED BY:

- Minors (under the age of majority in their state of residence) – Valid for 5 Years
- Applicants Ages 60-69 – Valid for 2 Years
- Applicants Ages 70 and older – Valid for 1 Year
- FIA Applicants – All Ages – Valid for 1 Year



PHYSICIAN EVALUATION FORM

You are being asked to examine this applicant for the purpose of obtaining an automobile racing license. This form is a guide for you to determine if the applicant is medically fit 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. See page 1 for driver requirements and racing environment.

FIA Applicants must also submit the following:

- Examination (Page 3) to be completed by physician, dated with 3 months of application.
- Medical History (Page 4) to be completed by applicant.
- Notes (Page 5) to be completed by physician/applicant as necessary.

Note to the examining physician: Please note the required submission frequency for this applicant based on their age group. If you believe the applicant's medical history or condition warrants more frequent evaluation, you may limit your approval to one year by noting in the Approved section below.

Medical conditions to consider in the decision to approve candidate

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

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.

For questions, contact SCCA at 1-800-770-2055

APPROVED

Physician evaluation completed.

Applicant is medically fit to participate in motor racing.

Pages (3,4,5) are required for FIA applicants.

Physician's Signature _____

Printed Name _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ Date _____

FAILED

Physician evaluation completed.

Applicant is not fit for motor racing.

Physician's Signature _____

Printed Name _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ Date _____



PHYSICIAN EXAMINATION FORM

To be completed by an MD, DO, PA-C or NP only. Any blanks will delay processing. There are five pages to this medical packet. The Physician Evaluation Form (page 2), Applicant's Medical History (page 4), and page 5 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: [] YES [] NO HgbA1C (less than 10) _____

VISION

Vision (use number 20/20) OD (Right: ____/____ OS (Left): ____/____ OU (Both): ____/____

Color Vision: _____ Test: _____

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

Comments and details of any condition noted above (Use page 5 for any explanations that do not fit here)

DO NOT SUBMIT THIS PAGE TO THE SCCA UNLESS YOU ARE APPLYING FOR AN FIA LICENSE.



APPLICANT'S MEDICAL HISTORY

(To be completed by applicant.)

Applicant: To obtain an FIA Competition License through the SCCA, and/or to provide your examining physician your history for their evaluation, 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, State, Zip: _____

Email: _____ Occupation: _____

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

Personal Physician: _____ Phone: _____

Address: _____ City, State, Zip: _____

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

Do you, 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 of 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, 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		
Illness(es) not listed above List:		
Do you require the use of supplemental oxygen or other external breathing device?		
Previous denial(s) from SCCA, NASA or other sanctioning body due to medical reasons?		

Blood Thinner Medication (circle) YES NO

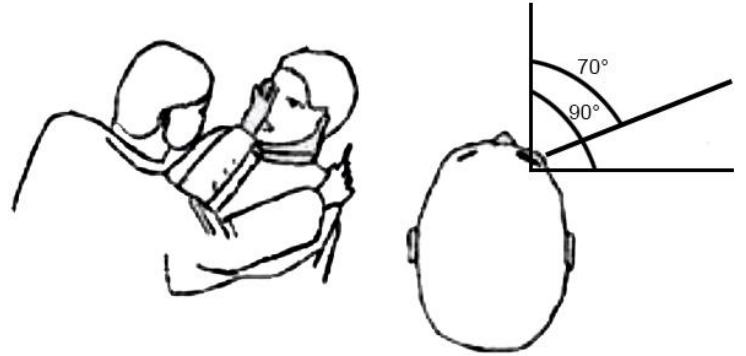
Comments and details of any condition noted above (Use the fourth page for any explanations that do not fit here) Medication Used (including eye drops) _____

DO NOT SUBMIT THIS PAGE TO THE SCCA UNLESS YOU ARE APPLYING FOR AN FIA LICENSE.

TIPS AND ADDITIONAL HISTORY/EXPLANATION

Tips on Peripheral Vision Exam:

Peripheral vision exam by confrontation is a 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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