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:

You are being asked to examine this applicant for the purpose of obtaining an automobile racing license. This form is a guide and tool for you to determine if the applicant is medically qualified 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.

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

Examination is to be completed by a Physician. Medical History is to be completed by the applicant.

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.
5. Ability to maintain an aerobic level heart rate for more than 20 minutes.

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 NASA or full FAA 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 70 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.

Note to Physician and Applicant: Medical Fitness of a Driver-Changes in Medical Condition after approved physical. Refer to GCR 2.3.2.A.3.
Examination
To be completed by a MD, DO, PA-C or NP only. Any blanks will delay processing!
Examination shall not be more than six (6) months old upon license application.
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: __________________________

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: _____No _____Yes HgbA1C (less than 10) __________________________

VISION
Vision (use numbers 20/20) OD (Right): ______/______ OS (Left): ______/______ OU (Both): ______/______
Color Vision: ___________________________ Test: __________________________
Peripheral Vision (use numbers) degrees from midline: _______ OD: _______ OS: _______ Test: __________

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 supplemental oxygen.)

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.
Please contact SCCA with any questions at 1-800-770-2055

APPROVED
Medical history and examination approved
Applicant is fit for motor racing
Additional review may apply for FIA applicants

Physician’s Signature __________________________
Printed Name ______________________________
Address ___________________________________
City __________________ State _____ Zip ______
Phone Number __________________ Date ______

FAILED
Applicant is not fit for motor racing

Physician’s Signature __________________________
Printed Name ______________________________
Address ___________________________________
City __________________ State _____ Zip ______
Phone Number __________________ Date ______
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.

Name: ___________________________________________ Age: _______ Date of Birth: ____________________________
Address: ________________________________________ City, St, Zip: ____________________________
Email Address: _________________________________ Occupation: ___________________________
Phone: (H) ___________________________ (W) ___________________________ (C) ___________________________
Personal Physician: ___________________________ Phone: ____________________________
Address: ______________________________________ City, St, Zip: ____________________________

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

<table>
<thead>
<tr>
<th>Do You Have or Have You Ever Had?</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Frequent or severe headaches</td>
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<tr>
<td>Unconsciousness for any reason</td>
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<tr>
<td>Dizziness or fainting spells</td>
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<tr>
<td>Epilepsy or seizures</td>
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<tr>
<td>Coronary artery disease or angina</td>
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<tr>
<td>Heart valve disease</td>
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<tr>
<td>Left Bundle Branch Block (heart)</td>
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<tr>
<td>Abnormal cardiac rhythms</td>
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<td></td>
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<tr>
<td>High Blood pressure</td>
<td></td>
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<tr>
<td>Operation(s) on brain</td>
<td></td>
<td></td>
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<tr>
<td>Operation(s) on heart</td>
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<td>Operation(s) on eyes, nerves, blood vessels, or bone</td>
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<tr>
<td>Previous waiver(s) from SCCA, NASA, or other sanctioning body for medical condition(s) list:</td>
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<table>
<thead>
<tr>
<th>Do You Have or Have You Ever Had?</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Any drug, narcotic, or alcohol problems</td>
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<tr>
<td>Psychiatric/mental health problems</td>
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<td>Eye trouble (except glasses)</td>
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<td>Asthma</td>
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<td>Diabetes requiring insulin</td>
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<td>Anemia or other blood diseases</td>
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<td>Including abnormal bleeding</td>
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<tr>
<td>Admission to a hospital in the past 12 months for any reason</td>
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<td>Allergy(s) to medications List:</td>
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<tr>
<td>Routine use of Pain Medication</td>
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<tr>
<td>Amputations/physical disability</td>
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<tr>
<td>Illness(es) not listed above List:</td>
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<tr>
<td>Do you require the use of supplemental oxygen or other external breathing device?</td>
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<tr>
<td>Previous denial(s) from SCCA, NASA, or other sanctioning body due to Medical reasons</td>
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</table>

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) ____________________________________________________________

Members Signature ___________________________________________ Date ____________________________

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SCCA Member Services - P.O. Box 299, Topeka, KS 66601-0299 Fax: 785-232-7213 E-Mail: membership@scca.com

Revised 6/17 Previous versions are obsolete
Tips on Peripheral Vision Exam:

Peripheral vision exam by confrontation is 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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