SCCA
Sports Car Club of America.

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.

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

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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 _____

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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.

Member # _____

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:

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:		
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) _____

_____

Members Signature_____ **Date** _____

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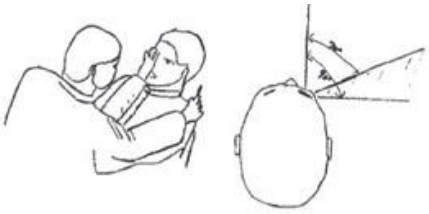
Tips on Peripheral Vision Exam:

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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