Physician's Examination and Medical History Forms

For Competition Licenses

Reverse side of form to be completed by examining Medical Doctor and returned to the applicant. Any blanks will delay processing of the license!

Dear Doctor,

You are being asked to examine this applicant for the purpose of obtaining a competition racing license issued by the Sports Car Club of America (SCCA). This Form concentrates on the organ system and disease processes that may jeopardize the applicant or others attending competition race events.

The Functional requirements of a driver in a competition automobile are:

1. Ability to rapidly operate acceleration, braking and steering mechanisms/systems (mechanical assistance allowed).
2. Vision: distant vision correctable to 20/40 in the better eye and the ability to distinguish basic color (red, green & yellow), and peripheral vision to 45 degrees in the horizontal median of each eye.
3. Minimal chance of sudden incapacitation from any disease process.
4. Ability for rapid mental activity and problem solving.

The environment this applicant may operate in is:

1. Temperature extremes from 0 to 120 degrees external to the vehicle (hotter inside).
2. Smoke, fumes, vapor and dust.
3. Noise and vibration.
4. Potential for the presence of fire.

Any place where consults are needed, the consultant must have a significant knowledge of the disease process and the high speed racing environment. The consultant does not have to be a specialist in the particular disease process.

Applicants who have not received a medical waiver are required to submit a current physical examination:

every five (5) years for those 16-35 year of age
every two (2) years for those 36 - 59 years of age
each year for those 60 years of age and older

Requirements for applicants who have received a medical waiver are defined by the SCCA Medical Board.

Thank you,

Sincerely,

The SCCA Medical Board

Physician's Examination

To be completed by a Medical Doctor. Any blanks will delay processing!

Examination date shall be no more than three (3) months prior to the date of application.

Applicant's Name:_____ Age:_____ Member #:_____

NOTES: Candidates having the following afflictions must be referred to the SCCA Medical Board for review:

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. Loss of extremity or eye
6. Diabetes
7. Loss of color vision
8. Psychological problems
9. Epilepsy
10. History of Heart Attack

Blood Pressure:_____ Pulse:_____ Respiration:_____Weight:_____ Height:_____

VISION *Abnormalities require an attached ophthalmological consult*

Vision (use numbers) Right:_____ Left:_____ Both :_____
Color Vision: (Red: Yes ___, No___) (Green: Yes___, No___) (Yellow: Yes___, No___)
Peripheral Vision (use numbers) degrees from midline:_____Right:_____Left: _____Test:_____

NEUROLOGICAL *Abnormalities require an attached neurological consult*

Reflexes: _____Normal _____Abnormal
Other tests performed:_____

CARDIAC *Abnormalities require an attached cardiologic consult*

Cardiac Exam: _____Normal _____Abnormal

EKG's need to be completed and attached *only if the candidate has an abnormal EKG or is a smoker, has a history of cardiac disease, diabetes: Insulin required (annual), Non Insulin required (based on age), or has hypertension or blood pressure reading > 140 systolic or 90 diastolic, and must be repeated every 5 years.*

METABOLIC *Please attach an HgbA1C for Diabetes.*

Diabetes: : _____No _____Yes Insulin: _____Yes _____No
Evidence of end-organ damage? ____Yes ____No HgbA1C (less than 10)_____

Comments or concerns that the SCCA Medical Board should be aware of: _____

Comments regarding current medications the applicant is taking (any side effects): _____

Examining Physician's Comments regarding applicant's medical history: _____

On the basis of this limited examination, review of the patient's history, and the instruction addressed to me, I (check one):

_____ **Recommend that this examinee be considered for medical approval to participate in high speed automobile competition events.**

_____ **Recommend that this examinee's medical information be reviewed by the SCCA Medical Review Board.**

Physician Signature and Stamp: Phone: (_____)_____

Signature:_____ **Date:** _____

SCCA Licensing/Membership - P.O. Box 19400, Topeka, KS 66619-0400 -1-800-770-2055 - 785-232-7213 Fax - www.scca.com

Applicant's Medical History

Applicant: For the purpose of obtaining a SCCA Competition License, complete this page legibly and in its <u>entirety</u>. Examining Physician must complete the Physician's Examination page.

Member #_____

Name:_____ Age:_____Date of Birth:_____

Address:_____City, St. Zip:_____

Phone:(_____)_____ (H), (_____)_____(W) Email:_____

Occupation:_____Sex:_____Marital Status:_____Years as a licensed racer:_____

Personal Physician:_____Phone:(_____)_____

Address:_____City, St, Zip:_____

YES RESPONSES AND ANY MEDICATIONS, should be explained on reverse side of this page and submitted with a physical exam.

Conditions	Yes	No
Diabetes: Insulin needed		
Insulin not needed		
Epilepsy or Seizures		
Heart Trouble: Coronary Artery Disease or Angina		
Valve Disease		
Left Bundle Branch Block		
Abnormal Cardiac Rhythms		
High Blood Pressure		
Any Drug, Narcotic or alcohol problems		
Amputation/Physical disability		
Anemia, or other blood disease including abnormal bleeding		
Cancer		
Dizziness or Fainting spells		

Conditions	Yes	No
Psychiatric/Mental Health Problems		
Operation s) involving Eyes, Brain,Heart, Nerves, Blood Vessels, or Bones		
Previous waiver(s) from SCCA for medical condition(s). List:		
Previous denial(s) from SCCA due to medical reason(s). List:		
Admission to the hospital in the past 12 months. Why?		
Illness(es) not mentioned above, List:		
Unconsciousness for any reason		
Eye trouble (except glasses)		
Allergy(s) to medications. List:		

Date of last Tetanus:_____ Blood Type (if known):_____

List Medications: _____

_____

_____

This is to certify that these statements are true and accurate.

Applicant's Signature: _____**Date:** _____

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Applicant's Medical History

Please explain in detail all Yes responses and any medication listed on the Medical History form:

Illnesses not previously listed elsewhere:_____

Comments:_____

This is to certify that these statements are true and accurate.

Applicant's Signature: _____ **Date:** _____

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