Examination and Medical History Forms

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!

Dear Doctor, PA or NP,

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.

Applicants are required to submit a current physical examination:

every five (5) years for those 16-39 years of age
every three (3) years for those 40-49 years of age
every two (2) years for those 50-59 years of age
every year for those 60 years of age and older

Unless you have been notified of the need to submit current physical examination more frequently.

Thank you,

The SCCA Medical Review Board

Examination

To be completed by a MD, DO, PA-C or NP only. Any blanks will delay processing!

Examination shall not be more than three (3) months old upon license application.

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

IMPORTANT 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
11. History of Cardiac Disaese
12. Loss of consciousness

EKG's need to be completed and attached for the following conditions:

1. Abnormal EKG
2. Smoker
3. History of Cardiac Disease
4. Hypertension/Blood Pressure
   a) reading > 140 systolic or 90 diastolic
   b) treated by physician - every 5 years
5. Diabetes:
   a) Insulin - required annual
   b) Non Insulin - required per medical exam age group

Abnormalities *require an attached Vision-ophthalmological, Neurological or Cardiologic consult.*

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

NEUROLOGICAL *Abnormalities refer to above*
Reflexes: ____Normal ____Abnormal
Other tests performed:_____

CARDIAC *Abnormalities refer to above*
Cardiac Exam: ____Normal ____Abnormal

METABOLIC *Please attach an HgbA1C for Diabetic.*
Diabetic : _____No _____Yes Insulin: _____Yes _____No HgbA1C (less than 10)_____
Evidence of end-organ damage? ____Yes ____No

VISION *Abnormalities refer to above*
Vision (use numbers) Right:_____ Left:_____ Both :_____
Color Vision "Can You See": (Red: Yes ___, No___) (Green: Yes___, No___) (Yellow: Yes___, No___)
Peripheral Vision (use numbers) degrees from midline:_____Right:_____Left: _____Test:_____

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.**

Signature and Stamp (INCLUDE CREDENTIALS otherwise it may not be accepted): Phone: (_____)_____

Signature:_____ **Date:** _____

SCCA Member Services - P.O. Box 299, Topeka, KS 66601-0299 - 1-800-770-2055 - 785-232-7213 Fax - membership@scca.com

Applicant's Medical History

Applicant: For the purpose of obtaining a SCCA Competition License, complete this page legibly and in its entirety. Examiner (MD, DO, PA-C, NP) must complete the Examination page.

Member #_____

Name:_____ Age:_____Date of Birth:_____

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		
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 (Last 5 years)		
Psychiatric/Mental Health Problems		

Conditions	Yes	No
Dizziness or Fainting spells		
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?		
Allergy(s) to medications. List:		
Unconsciousness for any reason		
Eye trouble (except glasses)		
Illness(es) not mentioned above, List:		

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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