March 2001

Physical Examination form for the purpose of obtaining a CFRA Competition License. Reverse side of form to be completed by examining Medical Doctor and returned to the applicant.

Dear Doctor,

You are being asked to examine this applicant for the purpose of obtaining a competition racing license issued by the Checkered Flag Racing Association (CFRA). This form concentrates on the organ system and disease processes that may jeopardize the applicant or others attending a competition race event.

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 each eye, ability to distinguish basic colors, and peripheral vision to 70 degrees in the horizontal median for 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 years 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 CFRA Board.

Thank you for your input.

Sincerely,

The CFRA Board

Attachment.

APPLICANT'S MEDICAL HISTORY

(To be completed by applicant)

Applicant: For the purpose of obtaining a CFRA Competition License, complete this page legibly and in its entirety. Failure to complete required information will delay the processing of your license. Examining Physician must complete the reverse side of this form.

Name: _____ Age: _____ Date of Birth: _____

Address: _____City, St. Zip: _____

Phone: (H) (___) _____ (W) (___) _____ Region of Record: _____

Occupation: _____ Sex: _____ Martial Status: _____ Years as licensed racer: _____

Your Personal Physician: _____ Phone:( ) _____

Address: _____City, St. Zip: _____

Examining Physician : _____ Phone: ( ) _____

Address: _____City, St. Zip: _____

A. Have you been treated for, have you ever had, or have you now, any of the following:
(Yes responses should be explained on a separate sheet and attached when submitted)

Conditions	Yes	No
Frequent or severe headaches		
Unconsciousness for any reason		
Dizziness or fainting spells		
Epilepsy or Seizures		
Heart Trouble:		
Coronary Artery Disease or Angina		
Valve disease		
Left Bundle Brach Block		
Abnormal Cardiac Rhythms		
High Blood Pressure		
Any drug, narcotic or alcohol problems		
Psychiatric/Mental Health Problems		
Operation(s) involving Eyes, Brain, Heart, Nerves, Blood Vessels, or Bones		
Previous waiver(s) from CFRA for a medical condition: List:		

Conditions	Yes	No
Hay fever		
Eye trouble (except glasses)		
Asthma		
Diabetes		
Anemia, or other blood diseases including abnormal bleeding		
Admission to a hospital in the past 12 months		
Allergy(s) to medications List:		
Amputations /Physical disability		
Previous denial(s) from CFRA due to a medical reason(s) List:		
Illness(s) not mentioned above List:		

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

Comments:_____

_____

Medications Used (including eye drops): _____

_____

This is to certify that these statements are true and accurate. I also give permission to any hospital, institution, or physician to furnish any information to the CFRA Board.

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

PHYSICIAN'S EXAMINATION **To be completed by a Medical Doctor**

Applicant's Name: _____ Age: _____ Sex:_____ Height:_____

Weight:_____ Hair Color: _____ Eye Color:_____

Blood Pressure: _____ Pulse: _____ Respirations:_____

NOTE: Candidates having the following afflictions must be referred to the CFRA 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

VISION *Abnormalities require an attached ophthalmologic consult*

Vision OD: _____ OS:_____ OU:_____

Color Vision: _____ Test:_____

Peripheral Vision (degrees from midline):_____ OD:_____ OS: _____Test:_____

NEUROLOGICAL *Abnormalities require an attached neurological consult*

Reflexes: ____ Normal ____ Abnormal Cerebellar: ____ Normal ____ Abnormal

Other tests performed: _____

CARDIAC *Abnormalities require an attached cardiology consult*

At the age of 40, a baseline EKG should be performed. Further EKG's need to be completed only if the candidate is a smoker, has a cardiac history, a strong family history of cardiac disease, history of diabetes, or has hypertension (systolic > 140, diastolic > 90). Cardiac Exam: _____ Normal _____ Abnormal

Please attach a copy of the EKG results.

METABOLIC *Please attach an HgbA1C and Endocrinology consult for any history of Diabetes.*

History of Diabetes: _____Yes _____ No HgbA1C (less than 10)_____

Comments or concerns that the CFRA 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 instructions addressed to me, I (check one): ____ *Find the candidate medically acceptable to operate a high-speed competition automobile.*

____*Recommend the candidate's medical history be reviewed by the CFRA Board.*

Signed: _____ **Date:** _____

Printed Name: _____ Phone: (___)_____

Address: _____City, St. Zip _____