

**Physical Examination form for the purpose of obtaining an SCCA 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 Sports Car Club of America (SCCA). 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 SCCA Medical Board.

Thank you for your input.

Sincerely,

*The SCCA Medical Board*

Attachment



## APPLICANT'S MEDICAL HISTORY

(To be completed by applicant)

**Applicant:** For the purpose of obtaining an SCCA 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 SCCA 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 SCCA 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 SCCA Medical 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 SCCA Medical Board for review:

- |   |                             |                             |
|---|-----------------------------|-----------------------------|
| 1. Less than 20/40 corrected vision in the better eye   | 5. Loss of extremity or eye | 8. Psychological problems   |
| 2. Alcoholic or drug addiction                          | 6. Diabetes                 | 9. Epilepsy                 |
| 3. Blood pressure: Diastolic over 90, systolic over 160 | 7. Loss of color vision     | 10. History of Heart Attack |
| 4. All gross deformities subject to listing             |                             |                             |

## **VISION** *Abnormalities require an attached ophthalmological 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 cardiologic 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 Endocrinologic consult for any history of Diabetes.*

History of Diabetes: \_\_\_\_\_ 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 applicants 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 SCCA Medical Board.*

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Printed Name: \_\_\_\_\_ Phone: (       ) \_\_\_\_\_

Address: \_\_\_\_\_ City, St. Zip \_\_\_\_\_