



# ICSCC 2011 PHYSICAL EXAMINATION FORM FOR COMPETITION LICENSE

(To be filled out by the examining physician)

Dear Doctor: This candidate wishes to take part in motor racing events in which he/she will drive a high performance car under the most exacting and stressful conditions. Examine him/her carefully and critically, and recommend him/her if medically fit to drive without danger to himself/herself or to others. If you are not sure of this decision, please indicate below for review of this applicant's suitability by an appropriate officer of the licensing body.

Name: _____	Birthdate: _____	Sex: _____
Address: _____		
City: _____	Height: _____	Weight: _____

NORMAL	ABNORMAL
_____ 1. Head and neck	_____
_____ 2. Ears and hearing	_____
_____ 3. Eyes	_____
_____ 4. Heart	_____
_____ 5. Peripheral pulses	_____
_____ 6. Gastro-Intestinal System	_____
_____ 7. Endocrine system	_____
_____ 8. CNS	_____
_____ 9. Peripheral nerves	_____
_____ 10. Genital/Urinary system	_____
_____ 11. Musculo-skeletal system	_____
_____ 12. Skin. Scars?	_____
_____ 13. Psychiatric disorder	_____

  

<p><b>An EKG is <u>NOT</u> required as of November 13, 2004.</b></p> <p><b><u>FOR DIABETICS ONLY:</u></b>          HgBA<sub>1</sub>C measured in the past two months. _____</p>	<p>14. <b><u>Distant Vision</u></b>          Right eye: 20/ _____          Left eye: 20/ _____          Both eyes: 20/ _____  <b><u>With Glasses</u></b>          Right eye: 20/ _____          Left eye: 20/ _____          Both eyes: 20/ _____</p> <p>15. <b><u>Field of Vision</u></b>          Normal _____          Abnormal _____</p> <p>16. <b><u>Color Vision</u></b>          Normal _____          Abnormal _____</p> <p>17. B. P. _____</p> <p>18. Heart Rate and rhythm: _____</p> <p>19. Urinalysis          Protein _____          Glucose _____</p>
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PHYSICIAN'S COMMENTS (may continue on the back of this form)

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- I believe that the applicant **is fit** to drive a racing car in competitive events at high speeds.
- This applicant **should be reviewed** by an ICSCC official.

**Physician's Signature:** \_\_\_\_\_  
**Date:** \_\_\_\_\_

Place physician's office stamp below  
 (physician's name, phone and address):