MEDICAL EXAMINATION

MEDICAL PRACTITIONER PLEASE NOTE:

Full Name:			
Racing Section:		**Age:**	

SECTION 3 - TO BE COMPLETED BY A MEDICAL PRACTITIONER - AND MUST SITE PHOTO ID OF APPLICANT

What is the applicant's:	Height (in cm)	Weight (in kg)	Body Mass Index	Pulse Rate	Blood Pressure

		Normal	Abnormal	Comments
3.1	History suggesting Heart Disease?			
3.2	Heart Sounds			
3.3	Peripheral Circulation			
3.4	History suggesting Respiratory Disease?			
3.5	Respiratory system			
3.6	Abdomen / Gastro-Intestinal System			
3.7	History suggesting psychiatric or neurological problems?			
3.8	Cranial Nerves			
3.9	Upper Limbs - Power, Tone and Reflexes			
3.10	Lower Limbs - Power, Tone and Reflexes			
3.11	Skeletal System and Joint System			
3.12	Hearing / Vestibular System			
3.13	Co-ordination			
3.14	Urine Testing			
3.15	History suggesting visual problems?			
3.16	Visual Fields			
3.17	Eye Movements			
3.18	Cover Test			
3.19	Colour Vision (Ishihara)			

Visual Acuity	Left	Right	Comments
Unaided	/ 6	/ 6	
With correction	/ 6	/ 6	

Please attach separate page(s) if space is not sufficient for required information.

SECTION 4 - MEDICAL PRACTITIONER'S DECLARATION

Statement to be completed by Medical Practitioner:

I have personally examined the applicant on / / (Must be dated) and verified the applicant's identity by siting photo ID.

On the basis of my examination and the information supplied to me by the applicant:

☐ I could find no evidence of any physical or mental illness that would exclude the applicant from competing in speedway racing.

☐ I consider that the applicant may be suffering from a medical condition that might have an adverse effect upon the ability to compete safely in speedway racing.
Please provide reason for above: _____

_____

Please tick applicable box and attach any information that might assist the SCCA medical advisory committee in determining this applicant's fitness to compete. If you have ticked that you feel they can not compete due to an illness, please specify any medication & dosage that will assist our Medical Practitioner in reviewing this application.

Name, address and Provider Number of medical practitioner:

_____

_____

_____

_____

Signed _____

MEDICAL - IN CONFIDENCE