Examination and Medical History Forms

Form to be completed by examiner (MD, DO, PA-C or NP) and returned to the applicant.

A. The functional suggested requirements of a driver in a competition automobile are:

1. Ability to rapidly operate acceleration, braking, and steering mechanisms/systems.
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. Should have minimal chance of sudden incapacitation from any disease process.
4. Ability for rapid mental activity, problem solving, and decision-making. 5. Ability to maintain an aerobic level heart rate for more than 20 minutes.

B. The environment this applicant may operate in is

1. Temperature extremes from 0 degrees (F) to 120 degrees (F) for long periods of time.
2. Smoke, fumes, vapor, caustic chemicals, and dust.
3. Loud noise and vibration.
4. Increased potential for exposure to fire

Renewals:

Applicants that are less than 40 years old must renew their Physical Examination every five years.
Applicants that are at least 40 years old must renew their Physical Examination every three years.
Applicants that are at least 50 years old must renew their Physical Examination every two years.
Applicants that are at least 70 years old must renew their Physical every 12 months.

ARC Racing Examination

To be completed by a MD, DO, PA-C or NP only. Any blanks will delay processing!
Examination shall not be more than six (6) months old.

Applicant's Name: _____ Date: _____ Age: _____
Sex: F | U | M
Hair Color: _____ Eyes Color: _____

Blood Pressure: | Pulse: | Respiration | Weight: | Height

NEUROLOGICAL Reflexes: Normal | Abnormal

CARDIAC Exam: Normal | Abnormal

METABOLIC: HbA1C No | Yes

HbA1C Level _____

VISION Vision (use numbers 20/20) OD (Right) : _____/_____ OS (Left): _____/_____ OU (Both): _____/_____ Color Vision: _____ **Test: Passed | Failed**
Peripheral Vision (use numbers) degrees from midline: _____ OD: _____ OS: _____
Test: Passed | Failed

Physical Exam

PASSED | FAILED

Physician's Signature _____ Printed Name _____
Address _____ City _____ State _____
Zip _____ Phone Number _____Date _____

Applicant's Medical History

Name: _____Age: _____ Date of Birth: _____
Address: _____ City: _____ State:_____
Zip: _____ Email Address: _____ Phone _____
Personal Physician: _____ Phone:_____
Address: _____ City: _____ State:_____ Zip: _____

Do You Have or Have You Ever Had?	YES	NO
Frequent or severe headaches		
Unconsciousness for any reason		
Dizziness or fainting spells		
Epilepsy or seizures		
Coronary artery disease or angina		
Heart valve disease		
Left Bundle Branch Block (heart)		
Abnormal cardiac rhythms		
High Blood pressure		
Operation(s) on brain		
Operation(s) on heart		
Operation(s) on eyes, nerves, blood Vessels, or bone		
Any drug, narcotic, or alcohol problems		

Psychiatric/mental health problems		
Eye trouble (except glasses)		
Asthma		
Diabetes requiring insulin		
Anemia or other blood diseases Including abnormal bleeding		
Admission to a hospital in the past 12 months for any reason		
Allergy(s) to medications		
Routine use of Pain Medication		
Amputations/physical disability		
Do you require the use of supplemental oxygen or other external breathing devices?		

Peripheral Vision Exam:

Peripheral vision exam by confrontation is a simple procedure. Position yourself so that your face is directly in front and on the same level with the patient, about 2 feet away. Ask the patient to cover one eye and to look at your eye directly opposite. Close your other eye so that your own visual field is roughly superimposed on that of the patient. Bring a pencil or other small object (light) from behind and from the periphery slowly into the patient's field of vision. Ask the patient to indicate when the object appears. Estimate in degrees the point where the patient sees the object to the point where the patient is looking directly ahead. Test the other eye in the same manner. Lack of adequate or impaired peripheral vision should be given special consideration.

Additional History or Comments: _____