



ICSCC 2024 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><u>FOR DIABETICS ONLY:</u> HgBA₁C measured in the past two months. _____</p>	<p>14. <u>Distant Vision</u> Right eye: 20/ _____ Left eye: 20/ _____ Both eyes: 20/ _____ <u>With Glasses</u> Right eye: 20/ _____ Left eye: 20/ _____ Both eyes: 20/ _____</p> <p>15. <u>Field of Vision</u> Normal _____ Abnormal _____</p> <p>16. <u>Color Vision</u> 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)

- 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.

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

Physician's Signature: _____

Date: _____