ICSCC PHYSICAL EXAMINATION FORM FOR COMPETITION LICENSE
(To be filled out by the examining physician)

valid for six months after the doctor's signature and date.

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	_____

FOR DIABETICS ONLY:
$HgBA_1C$ measured in the past two months. _____

14.	**Distant Vision**	
	Right eye:	20/ _____
	Left eye:	20/ _____
	Both eyes:	20/ _____
	With Glasses	
	Right eye:	20/ _____
	Left eye:	20/ _____
	Both eyes:	20/ _____
15.	**Field of Vision**	
	Normal	_____
	Abnormal	_____
16.	**Color Vision**	
	Normal	_____
	Abnormal	_____
17.	B. P.	_____
18.	Heart Rate and rhythm:	_____
19.	Urinalysis	
	Protein	_____
	Glucose	

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: _____