UNITED STATES AUTO CLUB

Medical Examination Form
USAC and FIA Driver's License

Last Name _____ **First Name** _____

Home Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____

Birth Date: _____ **Exam Date:** _____

Height: _____ **Weight:** _____ **Blood Type:** _____ **Last Tetanus:** _____

APPLICANT'S MEDICAL HISTORY

Do you have or have you ever had: **(Circle Y or N)**

Amnesia	Y or N	Arthritis	Y or N	Asthma	Y or N	Alcohol Abuse	Y or N
Dizziness	Y or N	Epilepsy	Y or N	Fainting	Y or N	Emotional Illness	Y or N
Hay Fever	Y or N	Hernia	Y or N	Kidney Disease	Y or N	Hypoglycemia	Y or N
Migraine	Y or N	Sinusitis	Y or N	Syphilis	Y or N	Vertigo	Y or N

Major Injuries: _____

Major Surgeries: _____

Hospitalization within last year: Y or N **When:** _____ **Where:** _____

Diagnosis: _____

Current Medications: _____

PHYSICAL EXAM

Ears/Hearing: _____ **Nose:** _____

Abdomen: _____ **Extremities:** _____

Blood Pressure: **Systolic:** _____ **Diastolic:** _____ **Rate (BPM):** _____ **Respirations/Min:** _____

Respiratory System (Describe): _____

Patient Name: _____

Heart (Condition and Size): _____

Sounds / Rhythm: _____

If age 40 or older:
EKG - Comments: _____

Nervous System/Reflexes: _____

EYE EXAM

Eyes: _____

LEFT EYE		**RIGHT EYE**	
Vision **Without** glasses/contacts	**20/** _____	Vision **Without** glasses/contacts	**20/** _____
Vision **With** glasses/contacts	**20/** _____	Vision **With** glasses/contacts	**20/** _____
Peripheral Vision: _____		Peripheral Vision: _____	
Can distinguish red, green, blue: _____		Can distinguish red, green, blue: _____	

I certify that the above information is correct and that I am physically and psychologically fit to drive a race car and/or a land speed record car at high speeds. Furthermore, I give permission to any health care facility or physician to release all information regarding recent injury or illness to the undersigned physician and/or medical director.

I understand that it is my responsibility to submit to a reexamination yearly and following any significant illness, injury or hospitalization. In addition, it is my responsibility to forward, or have forwarded all medical records from physicians and/or hospitals to the the medical director.

X _____ _____
Applicant's Signature Date

The applicant is medically fit to drive in competition at high speeds and is recommended for a license **with the following restrictions**:

Vision Correction Y or N _____

Other Restrictions: _____

X _____ _____
Examining Physician's Signature Date

_____
Address

_____ _____ _____ _____
City State ZIP Office Phone