IHRA Application for Driver's Medical Certificate

Name:_____ Date of Birth:_____

Address: _____

_____

INSTRUCTIONS FOR MEDICAL PHYSICIAN AND APPLICANT.

1. This examination is for a driver's racing competition license.
2. M.D. or D.O. must complete medical history information.
3. Record your medical findings. EKG required at age 55 and older.
4. Attach all findings, consults, ECG, EKG, x-rays to this report.
5. Page 2 of this form must be completed in full. If unable to complete or obtain any findings, refer patient to a second physician and attach any supplements.
6. M.D. or D.O. must sign page 2 of this form.

HAVE YOU EVER HAD OR NOW HAVE ANY OF THE FOLLOWING: *(For each "yes" checked, describe and date condition in the Additional Information section below).*

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Frequent or severe headaches	☐	☐	Heart trouble/Pacemaker	☐	☐	Nervous trouble of any sort	☐	☐	Medical rejection for military services
☐	☐	Dizziness or fainting spells	☐	☐	High or low blood pressure	☐	☐	Any drug or narcotic habit	☐	☐	Rejection for life insurance
☐	☐	Unconsciousness for any reason	☐	☐	Stomach trouble	☐	☐	Excessive drinking habit	☐	☐	Admission to hospital
☐	☐	Eye trouble except glasses	☐	☐	Kidney stone or blood in urine	☐	☐	Attempted suicide or suicidal thoughts	☐	☐	D.U.I.
☐	☐	Asthma/Hay fever	☐	☐	Sugar or albumin in urine / Diabetes	☐	☐	Motion sickness requiring drugs	☐	☐	Alcohol/Drug convictions
☐	☐	History of fractures	☐	☐	Epilepsy or fits/Seizures	☐	☐	Military medical discharge	☐	☐	Other illnesses

Additional Information: *(For each "yes" checked, describe and date condition)*

MEDICAL TREATMENT AND SURGICAL PROCEDURES WITHIN THE LAST 5 YEARS

Date	Name and Address of Physician Consulted	Reason

APPLICANT'S CERTIFICATION, AFFIRMATION & AGREEMENT: I hereby certify that all statements and answers provided by me in this medical form are true and complete, and I agree that they are to be considered part of the basis for issuance of any IHRA certificate or license to me. I understand and agree that if I give any untruthful information on this form, I forfeit any and all privileges to participate in any and every aspect of the sport of drag racing. I affirm that I have read, understand, and agree to be bound by all IHRA rules, regulations, and agreements. I understand and agree that IHRA may use the medical information provided on this form, and through any associated medical evaluation, for the purposes of operating the IHRA, determining my eligibility to obtain a license from IHRA, and evaluating my ability to safely participate in drag racing events. I acknowledge that IHRA's review of medical information is conducted on a limited basis, and that it is ultimately my responsibility, in consultation with my physician, to ensure that (i) I am in excellent physical health and condition and able to safely participate in hazardous activities, including drag racing in accordance with IHRA rules; (ii) I have no known medical condition that would impair my ability to safely participate in any event or create a danger to myself or others, including but not limited to conditions such as fainting, loss of balance, hemophilia or other clotting disorders, loss of muscular coordination, seizures, psychosis, or impaired and uncorrected vision; and (iii) I am not, and will not be, under the influence of any medications, drugs, or substances that may impair my ability to safely participate in drag racing or create danger to myself or others unless such medication is prescribed by a physician and has been disclosed to IHRA for review and approval in accordance with IHRA rules.

Signature of Applicant:_____ **Date:**_____

[PAGE 2 MUST BE COMPLETED]

AGE	DATE OF BIRTH	HEIGHT	WEIGHT	HAIR	EYES	SEX

APPLICANT'S NAME _____

REPORT OF MEDICAL EXAMINATION *(Please type or print)*

NORMAL	ABNORMAL	CHECK EACH ITEM IN APPROPRIATE COLUMN(Enter NE if not evaluated)
☐	☐	1. Head, face, neck and scalp
☐	☐	2. Nose
☐	☐	3. Sinuses
☐	☐	4. Mouth and throat
☐	☐	5. Ears, general
☐	☐	6. Drums (perforation)
☐	☐	7. Eyes, general (Visual acuity under items 27, 28 & 29)
☐	☐	8. Ophthalmoscopic
☐	☐	9. Pupils (Equality and reaction)
☐	☐	10. Ocular motility (Associated parallel movement, nystagmus)
☐	☐	11. Lungs and chest (Breasts exam only if clinically indicated or requested)
☐	☐	12. Heart (Precordial activity, rhythm, sounds and murmurs)
☐	☐	13. Vascular system (Pulse, amplitude and character; arms, legs, others)
☐	☐	14. Abdomen and viscera (Including hernia)
☐	☐	15. Anus and rectum (Digital exam only if clinically indicated or requested)
☐	☐	16. Endocrine system
☐	☐	17. G-U system (Pelvic exam only if clinically indicated or requested)
☐	☐	18. Upper and lower extremities (Strength and range of motion)
☐	☐	19. Spine, other Musculoskeletal
☐	☐	20. Identifying body marks, scars, tattoos
☐	☐	21. Skin and Lymphatics
☐	☐	22. Neurologic (Tendon reflexes, equilibrium, senses, cranial nerves,
☐	☐	23. Psychiatric (Appearance, behavior, mood, communication and memory)
☐	☐	24. General systemic

NOTES: Describe every abnormality in detail. Enter applicable item number before each comment. Use additional sheets if necessary and attach to this form.

25. BLOOD PRESSURE (Sitting MM Mercury)		26. HEART RATE	27. FIELD OF VISION (Peripheral)	28. DISTANT VISION (Must have BOTH findings)		
Systolic	Diastolic	Resting Pulse	☐ NORMAL ☐ ABNORMAL 29. **Corrective Lens REQUIRED While Driving** ☐ NO* ☐ YES **If previously "Yes," please include an explanation of the change.*		UNCORRECTED	CORRECTED
				Right Eye	20/	20/
				Left Eye	20/	20/
				Both Eyes	20/	20/

30. URINALYSIS *(If sugar is positive see #31.)*

SUGAR	ALBUMIN/PROTEIN	BLOOD
☐NO ☐YES		☐NO ☐YES

31. BLOOD SUGAR TEST *(Both Fasting & 2 Hour Post Prandial, required only if sugar is found in urine. No S.I. Units)*

FASTING	2-HOUR P.P.	HgA1C	COMMENTS

32. OTHER TESTS

33. DISQUALIFYING DEFECTS/LIMITATIONS

34. COMMENTS ON HISTORY AND FINDINGS, RECOMMENDATIONS *(INCLUDE SPECIFIC MEDICAL CONDITION AND MEDICATIONS CURRENTLY PRESCRIBED)*

35. EKG

CURRENT EKG REQUIRED AT AGE 55 AND OLDER | EKG must be dated within six months of this exam. | EKG must not reflect any abnormalities that would preclude the patient from racing. | ATTACH all findings, consults, ECG, X-rays, etc. to this report before mailing.

35.a EKG (Date)

MM	DD	YY

☐ NORMAL
☐ ABNORMAL

HEART TROUBLE WITHIN 2 YEARS, MUST SUBMIT RECENT EKG AND CARDIOLOGIST RELEASE.

36. PLEASE CHECK ONE

☐ **PHYSICALLY ACCEPTABLE**

☐ **FURTHER EVALUATION REQUIRED *(Explain)***

37. MEDICAL PHYSICIAN/D.O. DECLARATION: I hereby certify that I personally examined the applicant named on this medical report and that this report and any attachment embodies my findings completely and correctly. I have also reviewed the medical history on reverse side of form.

DATE OF EXAMINATION	MEDICAL PHYSICIAN SIGNATURE & STATE LICENSE NUMBER **(MD/DO ONLY)**	MEDICAL PHYSICIAN (MD/D0 ONLY) NAME, TITLE, ADDRESS & PHONE **(TYPE OR PRINT)**