COMPETITION LICENSE MEDICAL EVALUATION FORM

APPLICANT / RACER: Please Keep a Copy

***This is a four-page form**. It is to be completed by the applicant and examiner (MD or DO--all PA or NP examiners must have an MD/DO co-signature), and all pages must be signed and dated by both. It is the applicant's responsibility to forward this three-page form to the PCA Club Racing Office.* **Incomplete forms will delay review and approval**

Memorandum to Examining Physician:
The three pages of this form are collectively referred to as the "Medical Evaluation." You are being asked to examine this applicant for the purpose of obtaining a competition racing license issued by the Porsche Club of America (PCA) Club Racing. This form concentrates on the organ system and disease processes that may jeopardize the applicant or others attending a competition race event. If you deem that the applicant may be in questionable condition, the matter may be turned over to the PCA Club Racing Committee (including the Club Racing Medical Committee) for review.

RACING is a very physically demanding sport.
Please perform your evaluation and recommendation with that in mind.

Your recommendation for approval will be reviewed, but it is the final decision of the PCA Club Racing Committee whether or not an applicant is medically cleared for racing. At a minimum the conditions listed on page three will require review by the PCA Club Racing Committee. All three pages of the "Medical Evaluation" must be signed by the examining physician and the applicant.

Page One (this page) **-** Background information for the Medical Evaluation form and should be read carefully.
Page Two Medical History - to be completed by the applicant and reviewed by the examining physician.
Page Three Physical Examination - is to be completed by a MD/DO or an NP/PA with an MD/DO co-signature.

A. The functional requirements of a driver in a competition automobile are:
1. Ability to rapidly operate acceleration, braking, and steering mechanisms/systems.
2. Vision: (1) Distant binocular visual acuity of at least 20/40 (Snellen) in both eyes, with or without corrective lenses/contacts.
   (2) Field of vision of at least 70 degrees in the horizontal meridian in each eye. SEE PAGE 4.
   (3) Ability to recognize the colors of traffic signals and devices showing the standard red, green, blue, and yellow.
3. Should have minimal chance of sudden incapacitation from any disease process.
4. Ability for rapid mental activity, problem solving, and decision-making.

B. The environment this applicant may operate in is:
1. Temperature extremes from 0 degrees (F) to 120 degrees (F) or more 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.

Special Cases: In a case where consults are needed, the consultant should be made aware of the information in **Section A** and **Section B** of this memorandum. *Any explanations or consults, comments or concerns that the PCA Club Racing Committee should be aware of, comments regarding current medications the applicant is taking (any side effects) and any Physician's comments regarding medical history should be attached as a separate page.*

Requirement of All Applicants: All applicants must submit the completed form. Similar forms from other recognized organizations and agencies may be acceptable, however the applicant will be held accountable to the rules, laws, and other parameters, as set forth by PCA Club Racing.

Re-examination Intervals: Annually (1 year) OR Biennially (2 years). Racers with multiple or significant medical conditions may be required to undergo annual exams at the discretion of the Medical Safety Committee. Please check the appropriate option on page 3.

May attach business card for contact information – signature required

______________________ **Examiner Printed Name**	______________________ **Supervising Physician Printed Name**
Address ______________________	Address ______________________
City ______________ State/Zip ________	City ______________ State/Zip ________
Phone Number ______________________	Phone Number ______________________
	Reviewed:
______________________ **Applicant Signature** Date	______________________ **Examiner and Supervising Physician Signature** Date
Applicant Printed Name ______________________	

PCA CLUB RACING 1897 MISSION HILLS LANE NORTHBROOK, IL 60062
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COMPETITION LICENSE MEDICAL HISTORY FORM

To be completed by applicant and cosigned by MD/DO even if reviewed by PA/NP. Incomplete forms will not be processed. An Examining Physician must complete and must cosign this page. Incomplete forms will delay review and approval

To be submitted with a PCA Club Racing License Application or to update a Medical Evaluation Form on file.

Name ______________________________ Age ______ Birth Date __________ Sex ______

PCA Membership # __________________ PCA Region of Record __________ Single ______ Widowed ______

Occupation ______________________________ Married _______ Divorced _______

Phone (cell) __________________ (H or W) __________________ e-mail ______________________

Your Personal Physician ______________________________ Phone ______________________

Address ______________________________ City, St, ZIP ______________________

PLEASE INDICATE IF YOU EVER HAD, OR HAVE NOW, ANY OF THE FOLLOWING: Each "yes" answer to the conditions below requires a full explanation on a separate page. In addition, a physician clearance may also be required. Fulfillment of requests for additional information is the responsibility of the applicant.

Do You Have or Have You Ever Had?	Yes	No
1. Frequent or severe headaches		
2. Unconsciousness for any reason or fainting spells		
3. Dizziness or vertigo		
4. Epilepsy or seizures		
5. Coronary artery disease, angina or stents		
6. Heart valve problems or open heart surgery		
7. Left bundle branch block (heart)		
8. Abnormal cardiac rhythms, pacemaker, or AICD		
9. High blood pressure		
10. Operation(s) on brain, brain injury or concussion		
11. Operation(s) on heart		
12. Operation(s) on eyes, nerves, blood vessels, or bone		
13. Previous waiver(s) from PCA Club Racing, NASA, SCCA, BMWCCA, or other sanctioning body for medical condition(s)		

Do You Have or Have You Ever Had?	Yes	No
14. Any drug, narcotic, or alcohol problems		
15. Psychiatric/mental health problems		
16. Eye trouble (except glasses)		
17. Asthma, COPD, other pulmonary problem, or sleep apnea		
18. Diabetes		
19. Anemia or other blood diseases including abnormal bleeding		
20. Admission to a hospital in the past 12 months for any reason		
21. Allergy(s) to medications List:		
22. Routine use of Pain or sedative Medication (other than aspirin, tylenol, ibuprofen, NSAIDS)		
23. Amputations/physical disability		
24. Illness(es) not listed above List:		
25. Blood Thinner Medication of any kind		
26. Previous denial(s) from PCA Club Racing, , NASA, SCCA, BMWCCA, or other sanctioning body for medical condition(s)		

Date of last Tetanus __________ Are you taking any medication(s) with anticoagulant effects? ________YES __________NO

Medications Used (including eye drops and OTC Meds): ______________________________

Have you had an automobile accident, including racing, in the past two (2) years? ________ If "yes", explain on a separate page.

I certify that the above is true and correct information. I give my permission for the PCA Club Racing Committee (including the Club Racing Medical Committee) to access and/or exchange information with any health care providers or institutions as well as the medical administration of other sanctioning bodies. I will immediately notify PCA Club Racing if there is any change in my medical condition after the submission of this Medical Evaluation Form.

Reviewed by:

Applicant Signature Date **Examiner and Supervising Physican Signature** Date

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COMPETITION LICENSE PHYSICAL EXAMINATION FORM

To be completed by applicant and cosigned by MD/DO even if reviewed by PA/NP. Incomplete forms will not be processed. An Examining Physician must complete and must cosign this page. Incomplete forms will delay review and approval. ***Use a separate sheet page for any explanations.***

Name ____ Age _______ Birthdate _________________

Street Address ____ City/State/Zip ____________________________

Sex _______ Height ____________ Weight ___________ Color of Hair ______________ Color of Eyes __________

Blood Pressure ___________________ Pulse ____________ Respirations ______________________

IMPORTANT NOTES: Medical forms from candidates having the following conditions **must** be referred to the PCA Club Racing Committee for review. Medical forms requiring referral must be received in a timely fashion.

Less than 20/40 corrected vision in the better eye	*History of Syncope or loss of consciousness*	*Psychological problems*
Loss of color vision	*Epilepsy*	*Implanted Defibrillator*
Blood pressure: Diastolic over 90, Systolic over 160	*All gross deformities including loss of extremity or eye*	*History of any cardiac problem or Stroke/TIA*
Diabetes	*Alcoholic or drug addiction*	*Any examiner concern*

VISION *Significant abnormalities require an ophthalmological consult*

Vision Exam (list best acuity). 20/______ Right 20/______Left 20/______ Both **Corrected?** Yes____ No_____

Color Vision *(Normal is recognition of Red, Blue, Yellow, and Green)* Normal or Loss of Color Vision Test Used: ______________

PERIPHERAL/HORIZONTAL FIELD OF VISION **SEE PAGE 4.** *Normal is a field of vision of at least 70 degrees in the horizontal meridian in each eye. Indicate Normal OR, If less than 70 degrees, note degrees.*

Normal or Less than 70 DEGREES _____Right Eye Normal or Less than 70 DEGREES _____Left Eye Test Used: _________
note degrees *note degrees*

METABOLIC History of diabetes: ______ Yes ______ No
Are you on Insulin? ______ Yes ______ No

If yes, HgbA1C (less than 10) ____________ ***Please attach a current HgbA1c, EKG, and medical clearance for any history of Diabetes.***

CARDIAC *Abnormalities require cardiology consult*
Cardiac Exam: ________ Normal __________ Murmur _______ Irregular

A baseline EKG should be performed and submitted at age 40. A current EKG should be submitted by anyone with any cardiac or diabetic history or as requested by the PCA Club Racing Medical Committee.

NEUROLOGICAL *Abnormalities require neurological consult*

Examined item	Normal	Abnormal		Examined item	Normal	Abnormal
Cerebellar				*Reflexes*		
Cranial Nerves				*Sensation*		
Cognition				*Strength*		

RE-EXAMINATION: It is the responsibility of the applicant to present him/herself for re-examination as follows:

1. Upon expiration of his/her current medical examination form (as required by the current PCA Club Racing Rule Book)
   ____**ANNUAL (**1 year) **EXAMINATION** ____**BIENNIAL** (2 year) **EXAMINATION**
2. Following any significant illness, injury, or hospitalization experienced after this Physical Examination
3. Any time PCA Club Racing determines that good cause exists based on reasonable inquiry.

Based on this limited examination, and after review of all 3 pages, I RECOMMEND (acknowledging that PCA Club Racing Committee, including the Club Racing Medical Committee, has the final decision):

____The Applicant appears **FIT** for sport of competitive racing
____The Applicant appears fit, but I would like (or above rules require) this Medical Evaluation **BE REVIEWED** by PCA Club Racing Medical Committee
____The Applicant is **NOT CLEARED** by me for the sport of competitive racing

PHYSICIAN OFFICIAL STAMP or CARD HERE

Reviewed by:

______________________________________ ______________________________________
Applicant Signature Date **Examiner and Supervising Physician Signature** Date

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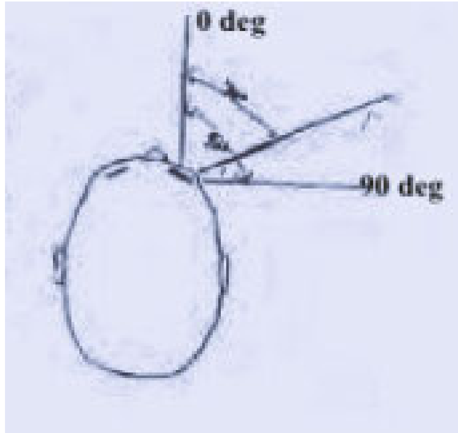
PERIPERAL VISION CHECK BY CONFRONTATION METHOD

Confrontation visual field testing:



The doctor faces the patient and asks the patient to look straight ahead at doctor's nose. Doctor has both hands out at 90 degrees from the midline of patient/doctor's gaze. The doctor wiggles LEFT finger, then the RIGHT finger, then both. While maintaining a straight-ahead gaze, the patient lets the doctor know when he/she can see the finger move in the peripheral vision by ***pointing*** to which side the finger is moving or both sides if both are moving. If correctly identified at 90 degrees, test is finished, result documented. If the patient fails at 90 degrees, then the doctor moves that wiggling side's finger closer to himself until the patient sees movement. Estimate of angle is then made and documented. 70 to 90 degrees is acceptable.