Medical Evaluation Form

medform@nasarallysport.com

Please Keep a Copy

This four page form 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 to NASA National. Any blanks will delay license processing!

Memorandum to Examining Physician:
The four 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 an automobile racing license. This form concentrates on the organ system and disease processes that may jeopardize the applicant or others while attending a competitive racing event. If you deem that the applicant may be in questionable condition, the matter may be turned over to the NASA Medical Director for review. **Your recommendation for approval will be reviewed, but it is the final decision of the NASA Medical Director** whether or not an applicant is medically cleared for racing. At a minimum the conditions listed on page three will require review by the Medical Director.

Page One (this page) – Background information for the Medical Evaluation form, and should be read carefully and signed by both the examining physician and the applicant.
Page Two Medical History is to be completed by the applicant, and reviewed and signed by the examining physician
Page Three Examination is to be completed by a MD/DO or an NP/PA with an MD/DO co-signature.
Page Four Comments. Any requested or necessary information signed by both the examining physician and the applicant.

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: distant vision correctable to 20/40 each eye, ability to distinguish basic colors, and peripheral vision to 45 degrees in the horizontal median for each eye.
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) 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.

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 NASA.

Renewal Intervals (minimum intervals without abnormalities):
***Exceptions:** Medical clearance may be granted in certain circumstances with the approval of the NASA Medical Director. NASA will stipulate any additional requirements or modified/shortened renewal intervals.
Applicants that are less than 40 years old must renew their Medical Evaluation every five years.
Applicants that are at least 40 years old must renew their Medical Evaluation every three years.
Applicants that are at least 50 years old must renew their Medical Evaluation every two years.
Applicants that are at least 70 years old must renew their Medical Evaluation every 12 months.

Reviewed: **Reviewed:**

Applicant Signature	Date	Examiner and Supervising Physician	Date

Applicant's Medical History

(To be completed by applicant and cosigned by MD/DO even if reviewed by PA/NP)

Applicant: For the purpose of obtaining a NASA Competition License, complete this page legibly and in its entirety. Failure to complete the information will delay processing of your license. The examining physician must cosign this page. **Note- the answer of "yes" for any condition highlighted below may be cause for review by the NASA Medical Director and Must have a comment on page 4.**

Name:_____ Member #: _____ Age:____ Date of Birth:_____

Address:_____ City, St, Zip:_____

Email Address: _____ Occupation:_____

Phone: (H) _____ (W) _____ (C)_____

Personal Physician: _____ Phone:_____

Address: _____ City, St, Zip:_____

Examining Physician: _____ Phone:_____

Address: _____ City, St, Zip:_____

PLEASE INDICATE IF YOU EVER HAD, OR HAVE NOW, ANY OF THE FOLLOWING:

Do You Have or Have You Ever Had?	Yes	No
1. Frequent or severe headaches		
2. Unconsciousness for any reason		
3. Dizziness or fainting spells		
4. Epilepsy or seizures		
5. Coronary artery disease or angina		
6. Heart valve Problems		
7. Left bundle branch block (heart)		
8. Abnormal cardiac rhythms		
9. High blood pressure		
10. Operation(s) on brain		
11. Operation(s) on heart		
12. Operation(s) on eyes, nerves, blood vessels, or bone		
13. Previous waiver(s) from NASA, SCCA, BMWCCA, PCA 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 or other pulmonary problem		
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 Medication		
23. Amputations/physical disability		
24. Illness(es) not listed above List:		
25. Blood Thinner Medication of any kind		
26. Previous denial(s) from NASA, SCCA, BMWCCA, PCA, or other sanctioning body due to medical reasons		

Date of last Tetanus_____ Blood Type_____

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 page 4.

I certify that the above is true and correct information. I give my permission for the NASA administration 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 NASA if there is any change in my medical condition.

Affirmed:_____ _____ **Reviewed:**_____ _____

Applicant Signature Date Examiner and Supervising Physician Date

Examination

To be completed by an MD, DO, PA-C or NP only (If done by PA/NP it must be co-signed by an MD/DO). Any blanks will delay processing!

Examination shall not be more than three (3) months old upon submission unless there is an active license with SCCA, BMWCCA, or PCA--then the expiration date will match that of the other accepted sanctioning body.

There are Four PAGES to this form. Please review and sign all 4 pages. Use the fourth page for any explanations.

Applicant's Name:_____ Date:_____ Member #:_____

Age:_____ Sex: _____ Hair Color:_____ Eye Color:_____

IMPORTANT NOTES: Drivers having the following Conditions **must** be referred to the NASA Medical Director for review:

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
Diabetes	Alcoholic or drug addiction	Any examiner concern

Exam Abnormalities *require an attached Ophthalmological, Neurological or Cardiology consultation.*

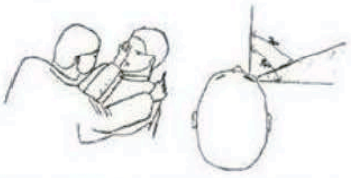
Blood Pressure: _____ Pulse:_____ Respirations:___ Weight:_____ Height:_____

METABOLIC History of diabetes: _____No _____Yes If yes, HgbA1C (less than 10)_____

CARDIAC *Abnormalities require cardiology consult*
Cardiac Exam: ____Normal ____Murmur ____Irregular
(A baseline EKG should be performed and submitted at age 40, with further EKG's to be determined by the NASA Medical Director.)

VISION *Abnormalities require an ophthalmological consult*
Vision (use numbers) Right:_____ Left:_____Both:_____ Color Vision:_____ Test Used:_____
Peripheral Vision (use numbers) degrees from midline: OD:_____OS:_____ Test Used:_____

Tips On Peripheral Vision Exam



Peripheral vision exam by confrontation is a simple procedure. Position yourself so that your face is directly in front and on the same level with the patient, about 2 feet away. Ask the patient to cover one eye and to look at your eye directly opposite. Close your other eye so that your own visual field is roughly superimposed on that of the patient. Bring a pencil or other small object (light) from behind and from the periphery slowly into the patient's field of vision. Ask the patient to indicate when the object appears. Estimate in degrees the point where the patient sees the object to the point where the patient is looking directly ahead. Test the other eye in the same manner. Lack of adequate or impaired peripheral vision should be given special consideration.

NEUROLOGICAL *Abnormalities require neurological consult*

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

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

Reviewed: **Reviewed:**

_____ _____ _____ _____
Applicant Signature Date Examiner and Supervising Physician Date

Additional History or Comments

Based on review of all 4 pages I RECOMMEND (acknowledging that NASA has the final decision):

☐	**The Applicant appears fit for competition automobile racing**
☐	**The Applicant appears fit, but I would like (or above rules require) his/her paperwork to be reviewed by the Medical Director**
☐	**The applicant is not cleared by me for automobile racing (Please email or fax immediately to medform@nasarallysport.com or 919-882-1883)**

Examiner Printed Name _____

Address _____

City _____ State_____ Zip_____

Phone Number _____ Date _____

Reviewed:

_____ _____
Applicant Signature Date

Supervising Physician _____

Address _____

City_____ State_____ Zip_____

Phone Number _____ Date _____

Reviewed:

_____ _____
Examiner and Supervising Physician Date