



# Medical Evaluation Form

[medform@nasarallysport.com](mailto: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

NASA Rally Sport, 25422 Trabuco Rd, Suite #105-276, Lake Forest, CA 92630 (646) 535-4240, (919) 882-1883 FAX [medform@nasarallysport.com](mailto:medform@nasarallysport.com)



## 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: \_\_\_\_\_ Date \_\_\_\_\_ Reviewed: \_\_\_\_\_ Date \_\_\_\_\_  
 Applicant Signature Examer and Supervising Physician

NASA Rally Sport, 25422 Trabuco Rd, Suite #105-276, Lake Forest, CA 92630 (646) 535-4240, (919) 882-1883 FAX medform@nasarallysport.com



# 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:** \_\_\_\_\_

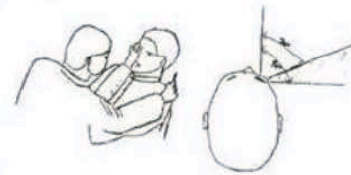
**METABOLIC** History of diabetes: \_\_\_\_\_ No \_\_\_\_\_ Yes If yes, HgbA1C (less than 10) \_\_\_\_\_

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

**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

NASA Rally Sport, 25422 Trabuco Rd, Suite #105-276, Lake Forest, CA 92630 (646) 535-4240, (919) 882-1883 FAX medform@nasarallysport.com



# Additional History or Comments

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

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

<input type="checkbox"/>	<b>The Applicant appears fit for competition automobile racing</b>
<input type="checkbox"/>	<b>The Applicant appears fit, but I would like (or above rules require) his/her paperwork to be reviewed by the Medical Director</b>
<input type="checkbox"/>	<b>The applicant is not cleared by me for automobile racing</b> <b>(Please email or fax immediately to <a href="mailto:medform@nasarallysport.com">medform@nasarallysport.com</a> or 919-882-1883)</b>

Examiner Printed Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number \_\_\_\_\_ Date \_\_\_\_\_

Supervising Physician \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number \_\_\_\_\_ Date \_\_\_\_\_

**Reviewed:**  
\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

**Reviewed:**  
\_\_\_\_\_  
Examiner and Supervising Physician

\_\_\_\_\_  
Date