



Documentation of Physical Exam of _____ for RMVR Racing License #: _____ (Please Print)
Date of Exam: _____ Applicant's birth date (mm/dd/year): _____

**To The Applicant:**

If you are between 18 and 35 years of age a physical examination is required every 5 years, 36 and older every 2 years. As applicant, you should fill out the needed applicant information this page (the RMVR Competition Medical Form) and page 1 of the two-page Physical Examination which is part of this packet. Upon completion of the two-page Physical Examination by your physician, **verify that this documentation Form has been fully completed and signed by both you and the physician.** Then **submit only this documentation Form** (not the two-page physical exam portion) to RMVR mailing it to: **32024 Snowshoe Road, Evergreen CO 80439. Do not send actual Physical Examination to RMVR!** However, you should retain a copy of this entire packet for your records should our club (or another you are racing with) wish to inspect it. This procedure is done to protect the privacy of your medical information.

As applicant, and by signing below, you understand that any alteration or forgery of this document is grounds to invalidate this exam and could result in expulsion from RMVR. You hereby authorize your physician to release to RMVR any medical information that may affect your ability to safely participate in RMVR racing events. You authorize RMVR to contact your physician to verify both that this exam was completed and that his recommendation is as shown below. You also agree to notify RMVR of changes in your health which may affect your ability to safely participate in vintage racing.

→ Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Applicant's Signature

**To the Examining Physician:**

This exam is required by RMVR to assure that the applicant is in good health and can be expected to withstand the rigors of vintage racing. Vintage automobile racing is a speed event involving numerous cars on the track at the same time. The drivers are protected by roll bars, restrained in the car by at least five point harnesses and must wear fire retardant clothing and helmets designed for auto racing. **Practice and race sessions typically last 15 to 30 minutes. The racing environment can be very hot and speeds for brief periods can be 90 to 150 mph.** If you have questions you may discuss them with the applicant or call RMVR at 303-319-3062. **NOTE: all candidates age 40 and over must have an ECG as part of this examination.**

After reviewing the above applicant's medical history and performing the physical examination prescribed on the attached Physical Examination, please sign both this document and the Physical Exam.

I, the examining physician, recommend that the applicant (check one):

→  **IS physically and psychologically fit to drive a racecar in competitive events at high speeds, OR**  
→  **IS NOT fit.**

→ Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Examining Physician's Signature  
Printed Name: \_\_\_\_\_ License # \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, ZIP \_\_\_\_\_ Phone: \_\_\_\_\_

**Physical Examination of \_\_\_\_\_ for RMVR Competition License**

**Applicant's Medical History**

(To be filled out by applicant prior to Exam)

Name:		Age:	Date of birth:	
Address:				
City:	State:	ZIP:	Phone(H):	Phone(W):
Sex:	Height:	Weight:	Eye Color:	Hair Color:
Do you currently have an RMVR Competition License? Yes/No If "Yes" what is that License Number? _____				
Personal Physician:			Phone:	
Examining Physician:			Phone:	

**Have you been treated for, ever had, or now have any of the following?**

(For each "YES" checked, describe or explain below. Attach additional sheets if necessary.)

Yes		No
	1. Frequent or severe headaches?	
	2. Unconsciousness for any reason?	
	3. Eye or vision trouble, except glasses?	
	4. Color blindness, glaucoma?	
	5. Asthma or other serious lung condition?	
	6. Allergy to medications or other drugs?	
	7. Diabetes I or II - Insulin and how much?	
	8. Heart attack, angina, heart failure, heart rhythm abnormality?	
	9. High or low blood pressure?	
	10. Anemia or other blood diseases, including abnormal bleeding?	
	11. Kidney, urinary tract disease, or stones?	
	12. Epilepsy, stroke, or seizure disorder?	
	13. Alcoholism or drug abuse?	
	14. Admission to hospital within the last 12 months? - Explain if "yes".	
	15. Operations involving eyes, brain, heart, nerves, or blood vessels?	
	16. Amputation or physical disability?	
	17. Psychological problems including depression?	
	18. Endocrine, hormone or immune system problem?	
	19. Have you ever been denied a competition license? - Explain if "yes".	
	20. Other serious illnesses?	

**Explanation or Remarks:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**List medication(s) currently used:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Physical Examination of \_\_\_\_\_ for RMVR Competition License

(Applicant's Name)

(The following to be filled out by the physician)

Normal	Please respond to all 21 items	Abnormal
	1. Head, face, neck and scalp	
	2. Sinus, mouth and throat	
	3. Ears: general, gross hearing loss	
	4. Eyes: general (visual acuity under item #16)	
	5. Pupils (equality & reaction)	
	6. Ocular motility (associated parallel movement)	
	7. Lungs and chest	
	8. Cardiovascular system	
	9. Abdomen	
	10. G-U system	
	11. Upper & lower extremities (strength and range of motion)	
	12. Spine, other musculo-skeletal	
	13. Neuralgic (tendon reflexes, equilibrium, senses, coordination, etc.)	
	14. Psychiatric (specify any serious personality deviation)	
	15. General systemic	

For Diabetics only:	Hb A1c _____%	
<u>No</u>		<u>Yes</u>
	History of hypoglycemic reaction?	
	Peripheral neuropathy?	
	Retinopathy?	

16. Distance Vision:	
Right eye-20/	Corrected to 20/
Left eye-20/	Corrected to 20/
Both eyes-20/	Corrected to 20/
17. Peripheral Vision (See below):	
Right Eye -	degrees
Left Eye -	degrees
18. Blood Pressure:	
Systolic -	
Diastolic -	
19. Pulse:	
Resting -	
20. Urinalysis:	
Protein -	
Glucose -	
21. ECG Results (Provide copy to applic.):	
Normal -	
Abnormal -	

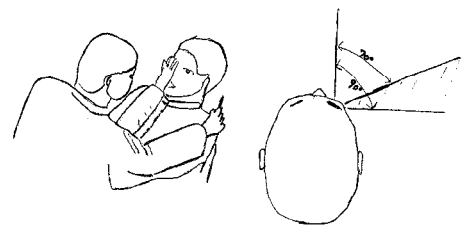
Additional Comments on medical history and/or findings: \_\_\_\_\_

Candidates having the following conditions should be given special considerations by the examining physician:

Less than 20/30 corrected vision in the better eye	Stroke or significant neurological abnormality
Loss of extremity or vision in an eye	History of any loss of consciousness
Alcohol or drug abuse	Asthma or any serious lung condition
Psychological problems	Blood pressure - systolic over 155, diastolic over 90
Diabetes	History of heart attack, failure, angina, or rhythm irregularity
History of malignant disease	

### Tips On Peripheral Vision Exam – Item #17 Above

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.



➔ **Signed:** \_\_\_\_\_  
Examining Physician

**Date:** \_\_\_\_\_  
Date