APPLICATION FOR DRIVER'S MEDICAL CERTIFICATE

APPLICANT'S FULL NAME & ADDRESS

Name _____

Address _____

_____

_____

_____

PHYSICAL EXAMINATION

INSTRUCTIONS FOR MEDICAL PHYSICIAN AND APPLICANT

1. This medical certificate must be completed by an M.D. or D.O. only.
2. This examination is for a driver's racing competition license.
3. M.D. or D.O. must complete medical history information.
4. Record your medical findings.
5. Application will be returned if any information is incomplete.
6. Reverse side of this form to be completed in full. If unable to complete or obtain any findings, refer patient to a second physician and attach any supplements.
7. M.D. or D.O. must sign reverse side of this form.
8. Application and attachments must be in English.
9. EKG required at age 55 and older, copy must be attached.
10. Attach all findings, consults, ECG, EKG, x-rays to this report.
11. Return completed original form to applicant. Copies not accepted.
12. LICENSE WILL BE VALID FOR TWO YEARS FROM THE MONTH OF THE PHYSICAL. (TOP FUEL AND FUNNY CAR VALID FOR ONE YEAR; ANNUAL RENEWAL)
13. Any matter, including without limitation any conditions or medications, in this examination may be referred to an NHRA medical consultant for review, and may be cause for rejection.

MEDICAL HISTORY

This should include any and all changes within the last two years

HAVE YOU EVER HAD OR HAVE NOW ANY OF THE FOLLOWING: *(For each "yes" checked, describe and date condition in remarks)*

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
☐	☐	a. Frequent or severe headaches	☐	☐	g. Heart trouble/Pacemaker	☐	☐	m. Nervous trouble of any sort	☐	☐	s. Medical rejection from or for military service
☐	☐	b. Dizziness or fainting spells	☐	☐	h. High or low blood pressure	☐	☐	n. Any drug or narcotic habit	☐	☐	t. Rejection for life insurance
☐	☐	c. Unconsciousness for any reason	☐	☐	i. Stomach trouble	☐	☐	o. Excessive drinking habit	☐	☐	u. Admission to hospital
☐	☐	d. Eye trouble except glasses	☐	☐	j. Kidney stone or blood in urine	☐	☐	p. Attempted suicide	☐	☐	v. D.U.I.
☐	☐	e. Asthma/Hay fever	☐	☐	k. Sugar or albumin in urine/Diabetes	☐	☐	q. Motion sickness requiring drugs	☐	☐	w. Alcohol/Drug convictions
☐	☐	f. History of fractures	☐	☐	l. Epilepsy or fits/Seizures	☐	☐	r. Military medical discharge	☐	☐	x. Other illnesses

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

MEDICAL TREATMENT INCLUDING SURGICAL PROCEDURES WITHIN THE LAST 5 YEARS *(continue on additional page if necessary)*

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 examination form are true and complete, and I agree that they are to be considered part of the basis for issuance of any NHRA 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 NHRA rules, regulations and agreements including, but not limited to, those contained in the applicable NHRA Rulebook, with specific reference, but not limited to the rules regulations and agreements contained in the Administration Procedures and Appeals Section of the applicable Rulebook which are incorporated herein by reference. I know that the NHRA Rulebook, including amendments, is available to me online. I agree that participation in any and every aspect of the sport of drag racing is a privilege, not a right, and I wish to participate in accordance with all of the foregoing. I further affirm all of the following: Drag racing is a dangerous sport. There is no such thing as a guaranteed safe drag race. Drag racing always carries with it the risk of serious injury or death in any number of ways. This risk will always exist no matter how much everyone connected with drag racing tries to make our sport safer. Although NHRA works to promote and enhance the safety of the sport, there are no guarantees that such safety measures will guarantee or ensure my safety. I as the participant always have the responsibility for my own safety, and by participating in drag racing, I am accepting all risks of injury, whether due to negligence, vehicle failure, or otherwise. If at any time I do not accept these risks, I will not participate in drag racing. I understand the NHRA Competition Number is issued solely for participation in drag racing on NHRA Member Tracks.

APPLICANT'S ACKNOWLEDGEMENT OF RESTRICTED MEDICATIONS: I state and affirm that I have read and understand the following classifications of medications and/or substances that are not allowed for use by any participant: all blood thinners, amphetamines, cocaine, marijuana (cannabis, THC), opiates and phencyclidine (PCP). NOTE: I understand that if there is a possibility that I have taken a medically prescribed Prohibited Substance, it is my responsibility to inform the NHRA National Field Office so that a medical review can be undertaken to determine whether it is acceptable or not. I understand that NHRA's Supervisor of Medical Affairs will make final decisions concerning medical drug clearance issues. I will cooperate in facilitating the medical review including without limitation providing requested medical records and undergoing a physical exam or other testing. I understand that this list of Prohibited Substances in Section 1.7 is for the purposes of this Substance Abuse Policy only and does not limit the substances medically reviewed and allowed or disallowed for purposes of licensure and other participation in NHRA racing, and that further information is in the NHRA Rulebook Section 1.6.1 regarding licensure.

SIGNATURE OF APPLICANT (In ink) _____ **DATE** _____

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, coordination, etc.)
☐	☐	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.)*			31. BLOOD SUGAR TEST *(Both Fasting & 2 Hour Post Prandial, required only if sugar is found in urine. No S.I. Units)*			
SUGAR	ALBUMIN/PROTEIN	BLOOD	FASTING	2-HOUR P.P.	HgA1C	COMMENTS
☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES				

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/DO ONLY) NAME, TITLE, ADDRESS & PHONE (TYPE OR PRINT)