PCA CLUB RACING 1897 MISSION HILLS LANE NORTHBROOK, IL 60062
pcaclubrace@aol.com phone: 847.272.7764 fax:847.919.6862

Medical Evaluation Form

APPLICANT: Please Keep a Copy

This three 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 the PCA Club Racing Office. Any blanks will delay approval of this Medical Evaluation!

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.

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 - to be completed by the applicant, and reviewed and signed 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: 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. *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) as determined by the examining Medical Doctor. Please check the appropriate option on page 3.

May attach business card for contact information

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

Applicant Printed Name ____

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APPLICANT'S / RACER'S MEDICAL HISTORY

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.

To be submitted with a PCA Club Racing License Application or to update a Medical Evaluation Form on file. Note-the answer of "YES" for any condition highlighted below may be cause for review by the PCA Club Racing Committee and must have a comment on a separate page.

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: For each "yes", explain on a separate page.

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 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 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 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 PCA Club Racing 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:

Applicant Signature ______ Date ______ Examiner and Supervising Physician Signature ______ Date ______

Revised 12/14: Previous versions are obsolete and will not be accepted/approved after 1/1/16

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PHYSICAL EXAMINATION FORM FOR A COMPETITION LICENSE

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! ***There are THREE PAGES to this form. Please review and sign all 3 pages. 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 NOTE: 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*

METABOLIC History of diabetes: _______No _______Yes If yes, HgbA1C (less than 10) ____________ *Please attach an HgbA1c and medical consult 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, with further EKG's to be determined by the PCA Club Racing Committee.)

VISION (use numbers) *Abnormalities require an ophthalmological consult*
Vision OD Right: _________ Left: _________ Both: _________ Color Vision:__________ Test Used: ________________

Peripheral Vision degrees from midline: OD: __________ OS: __________ Test Used:________________

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 for

   _______**ANNUAL (**1 year) **EXAMINATION** **OR** _______**BIENNIAL** (2 year) **EXAMINATION**

2. Following any significant illness, injury, or hospitalization experienced after this Physical Examination

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

PHYSICIAN OFFICIAL STAMP or CARD HERE (required)

____ The Applicant appears fit for sport of competitive racing

____ The Applicant appears fit, but I would like (or above rules require) this Medical Evaluation to be reviewed by the PCA Club Racing Committee

____ The applicant is NOT cleared by me for the sport of competitive racing

Reviewed: **Reviewed:**

______________________________ ______________________________
Applicant Signature Date Examiner and Supervising Physician Signature Date

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