



**NASA
Competition
License
Physical
Examination
Instructions**

Memorandum to Examining Physician:

The three pages of this form are collectively referred to as the "Physical Examination." 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.

Page One (this page) - instructions for completing the Physical Examination form, and should be read carefully by both the examining physician and the applicant.

Page Two of the Physical Examination form is to be completed by the applicant.

Page Three of the Physical Examination form is to be completed by a Physician.

A. The functional suggested 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 70 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 a completed *APPLICANT'S MEDICAL HISTORY* and *PHYSICIAN'S EXAM*. Similar forms from other recognized organization and agencies may be acceptable, however the applicant will be held accountable to the rules, laws, and other parameters, as set forth by the issuing organization or agency.

Renewals:

Applicants that are less than 40 years old must renew their Physical Examination every five years.
Applicants that are at least 40 years old must renew their Physical Examination every three years.
Applicants that are at least 50 years old must renew their Physical Examination every two years.
Applicants that are at least 60 years old must renew their Physical Examination every 12 months.

Note to the examining physician: Please note the "**Renewals**" section of this document (above).

Consideration should be given to the length of time between examinations, unless otherwise specified with highlighted notation in the comment section found on the PHYSICIAN'S EXAMINATION page of this document.

*** Exceptions:**

Medical Waivers may be granted in certain circumstances with the approval of the proper authorities, as listed on the Application for a Medical Waiver form. Drivers that have been granted a Medical Waiver may be subject to special requirements as the NASA Medical Director sees fit. Temporary Medical Waivers may be granted to the participants of other recognized organizations that are participating in a specific event as a "guest group," or events that are co-hosted or co-sanctioned at the discretion of the NASA Regional Director.

APPLICANT'S MEDICAL HISTORY

(To be completed by applicant)

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

Name _____ 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 have ever had, or have now, any of the following:

Conditions	Yes	No
Frequent or severe headaches		
Unconsciousness for any reason		
Dizziness or fainting spells		
Epilepsy or seizures		
Coronary artery disease or angina		
Heart valve disease		
Left Bundle Brach Block (heart)		
Abnormal cardiac rhythms		
High blood pressure		
Any drug, narcotic, or alcohol problems		
Psychiatric/ mental health problems		
Operation(s) on brain		
Operation(s) on heart		
Operation(s) on eyes, nerves, blood vessels, or bone		
Previous waiver(s) from NASA for medical condition(s) List:		

Conditions	Yes	No
Hay fever		
Eye trouble (except glasses)		
Asthma		
Diabetes		
Anemia or other blood diseases including abnormal bleeding		
Admission to a hospital in the past 12 months		
Allergy(s) to medications List:		
Amputations / physical disability		
Previous denial(s) from NASA, SCCA, or other sanctioning body due to medical reasons		
Illness(es) not listed above List:		

Date of last Tetanus _____ Blood Type _____ **Blood Thinner Medication** (circle) YES NO

Comments and details of any condition noted above _____

Medications Used (including eye drops) _____

I certify that the above is true and correct information. I also give my permission for the NASA administration to access and/ or exchange information with health care providers as well as the medical administration of other sanctioning bodies.

Applicant's Signature _____ Date _____

PHYSICIAN'S EXAMINATION (To be completed by a medical doctor)

Note- There are THREE PAGES to this form. Please see "APPLICANT'S MEDICAL HISTORY," and "NASA Competition License Physical Examination Instructions."

Applicant's Name _____ Date _____

Age _____ Sex _____ Height _____ Weight _____ Hair Color _____ Eye Color _____

Blood Pressure ___ / ___ Pulse _____ Respirations _____

Note: Applicant's having the following conditions must be referred to the NASA Medical Director for review:

- | | | |
|---|-----------------------------|--|
| 1. Less than 20/40 corrected vision in the better eye | 5. Loss of extremity or eye | 9. Epilepsy |
| 2. Alcohol or drug addiction | 6. Diabetes | 10. Implanted Defibrillator |
| 3. All gross deformities subject to listing | 7. Loss of color vision | 11. Coronary Artery Disease/Stent/CABG/or MI |
| 4. Blood pressure: Diastolic over 90 or systolic over 160 | 8. Psychological problems | 12. History of Cardiac Arrhythmias |
| | | 13. History of Syncope |

VISION Abnormalities require an attached ophthalmological consult

Vision OD _____ OS _____ OU _____

Color Vision _____ Test _____

Peripheral Vision (degrees from midline) _____ OD _____ OS _____ Test _____

NEUROLOGICAL Abnormalities require an attached neurological consult

Reflexes _____ Normal _____ Abnormal Cerebellar _____ Normal _____ Abnormal

Other test performed _____

CARDIAC Abnormalities require an attached cardiologic consult

At the age of 40, a baseline EKG should be performed. Further EKG's need to be completed only if the applicant is a smoker, has a cardiac history, a strong family history of cardiac disease, history of diabetes, or has hypertension (systolic > 140 or diastolic > 90).

Cardiac Exam _____ Normal _____ Abnormal

Please attach a copy of the EKG results.

METABOLIC Please attach an HgbA1C and Endocrinologic consult for any history of diabetes.

History of diabetes _____ Yes _____ No HgbA1C (less than 10) _____

Comments or concerns regarding past or present health, and / or medications (and side effects), that the NASA Medical Director should be aware of: _____

On the basis of this limited examination, review of APPLICANT'S MEDICAL HISTORY, and the instructions addressed to me, I conclude the following:

PASS: Applicant is fit for motor racing

Signature _____

Printed Name _____

Address _____

City _____ St _____ Zip _____

Phone Number _____

FAIL or REVIEW:

Applicant referred to NASA Medical Director

Printed Name _____

Address _____

City _____ St _____ Zip _____

Phone Number _____