



COMPETITION LICENSE MEDICAL EVALUATION FORM

APPLICANT / RACER: 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 three-page form to the PCA Club Racing Office. Incomplete forms will delay review and approval

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. All three pages of the "Medical Evaluation" must be signed by the examining physician and the applicant.

Page One (this page) - Background information for the Medical Evaluation form and should be read carefully.

Page Two Medical History - to be completed by the applicant and reviewed 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: (1) Distant visual acuity of at least 20/40 (Snellen) in each eye, with or without corrective lenses/contacts.
(2) Distant binocular visual acuity of at least 20/40 (Snellen) in both eyes, with or without corrective lenses/contacts.
(3) Field of vision of at least 70 degrees in the horizontal meridian in each eye.
(4) Ability to recognize the colors of traffic signals and devices showing the standard red, green, blue, and amber.
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 – signature required

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



COMPETITION LICENSE MEDICAL HISTORY FORM

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.

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: Each "yes" answer to the conditions below requires a full explanation on a separate page. In addition, a physician clearance may also be required. Fulfillment of requests for additional information is the responsibility of the applicant.

Do You Have or Have You Ever Had?	Yes	No
1. Frequent or severe headaches		
2. Unconsciousness for any reason or fainting spells		
3. Dizziness or vertigo		
4. Epilepsy or seizures		
5. Coronary artery disease, angina or stents		
6. Heart valve problems or open heart surgery		
7. Left bundle branch block (heart)		
8. Abnormal cardiac rhythms, pacemaker, or AICD		
9. High blood pressure		
10. Operation(s) on brain, brain injury or concussion		
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, other pulmonary problem, or sleep apnea		
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 (other than aspirin, tylenol, ibuprofen, NSAIDS)		
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 the PCA Club Racing Committee (including the Club Racing Medical Committee) 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 by:

Applicant Signature _____ Date _____

Examiner and Supervising Physician Signature _____ Date _____



COMPETITION LICENSE PHYSICAL EXAMINATION FORM

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. **Incomplete forms will delay review and approval**

Name _____ Age _____ Birthdate _____
Street Address _____ City/State/Zip _____
Sex _____ Height _____ Weight _____ Color of Hair _____ Color of Eyes _____
Blood Pressure _____ Pulse _____ Respirations _____

IMPORTANT NOTES: 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

VISION (use numbers) *Abnormalities require an ophthalmological consult*

Vision OD Right: _____ Left: _____ Both: _____ Color Vision: _____ Test Used: _____

Peripheral Vision degrees from horizontal median: OD: _____ OS: _____ Test Used: _____

METABOLIC History of diabetes: _____ No _____ Yes
Are you on Insulin? _____ No _____ Yes
If yes, HgbA1C (less than 10) _____ Please attach an HgbA1c, EKG, and medical clearance 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. A current EKG should be submitted by anyone with any cardiac or diabetic history or as requested by the PCA Club Racing Medical Committee.

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:

- 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**
- Following any significant illness, injury, or hospitalization experienced after this Physical Examination
- Any time PCA Club Racing determines that good cause exists based on reasonable inquiry.

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

- _____ 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 PCA Club Racing Committee (including the Club Racing Medical Committee)
- _____ The Applicant is NOT cleared by me for the sport of competitive racing

PHYSICIAN OFFICIAL STAMP or CARD HERE
(signature also required)

Reviewed by:

Applicant Signature	Date	Examiner and Supervising Physician Signature	Date
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