

AMERICAN GT ROAD RACING ASSOCIATION, LLC
Medical Examination Form for Membership

(Last Name)	(First Name)	(DOB)	(Examination Date)
<hr/>		<hr/>	
(Home Address)	(City)	(State)	(Zip Code)
<hr/>		<hr/>	
(Height)	(Weight)	(Blood Type)	(Last Tetanus)

APPLICANT'S MEDICAL HISTORY

Do you have or have you ever had: (circle Y or N)

epilepsy	Y or N	dizziness	Y or N	vertigo	Y or N	fainting	Y or N
arthritis	Y or N	migraine	Y or N	amnesia	Y or N	sinusitis	Y or N
syphilis	Y or N	asthma	Y or N	hay fever	Y or N	alcohol abuse	Y or N
hypoglycemia	Y or N	kidney disease	Y or N	emotional illness	Y or N		

Major injuries _____

Major operations _____

Hospitalization within last year _____ When _____ Where _____

Diagnosis _____

Current medications _____

MEDICAL EXAM

Ears _____

Nose _____

Abdomen _____

Extremities _____

Systolic pressure _____ Diastolic pressure _____ Respirations _____

Respiratory system description _____

Heart size _____

Name _____

Sounds/Rhythm _____

(Age 40 & over)

EKG - Comments _____

Nervous system _____

EYE EXAM

Eyes _____

Right Eye		Left Eye	
With glasses/contacts	20/ _____	With glasses/contacts	20/ _____
Without glasses/contacts	20/ _____	Without glasses/contacts	20/ _____
Visual Field	_____	Visual Field	_____
Can distinguish Red, Green, Blue	_____	Can distinguish Red, Green, Blue	_____

I certify that the above information is correct and that I am physically and psychologically fit to drive a race car in competition at high speeds. Furthermore, I give permission to any health care facility or physician to release all information regarding recent injury or illnesses to the undersigned medical director.

X _____
Applicant's Signature
Date

I understand it is my responsibility to submit to a reexamination yearly and following any significant illness, injury or hospitalization. In addition, it is my responsibility to forward, or have forwarded all medical records from physicians and/or hospitals to the medical director."

This applicant is medically fit to drive in competition at high speeds and is recommended for a license with the following restrictions:

Vision Correction Y or N _____

Shield Restriction Y or N _____

Other Restrictions _____

X _____
Examining Physician's Signature
Date