



INTERNATIONAL HOT ROD ASSOCIATION AUSTRALIA  
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# MEDICAL PHYSICAL FORM

Medical Examination Record Applicable to IHRA Australia licence holder ONLY  
 (must be completed by a Medical Practitioner registered to practice medicine in Australia)

RACE No \_\_\_\_\_

Surname \_\_\_\_\_ Given Names \_\_\_\_\_

Address \_\_\_\_\_

Suburb \_\_\_\_\_ State/Postcode \_\_\_\_\_

Phone \_\_\_\_\_ Mobile \_\_\_\_\_

D.O.B. \_\_\_\_\_ Male / Female \_\_\_\_\_

*The following section is to be completed by applicant PRIOR to seeing your Medical Practitioner*

## MEDICAL HISTORY

Have you ever had any of the following (for each "YES" checked describe conditions in Remarks below)

Y	N	CONDITIONS	Y	N	CONDITIONS
		Frequent or severe headaches			Motion sickness
		Dizziness or fainting spells			Earache or discharge from ear
		Indigestion, gastric or duodenal ulcers			High or Low blood pressure
		Kidney stone or blood in urine			Asthma
		Diabetes			Admission to hospital
		Sugar or albumen in urine			Any illness not already mentioned?
		Epilepsy or fits			Are you taking any prescribed medications?
		Heart trouble			

Remarks: \_\_\_\_\_  
 \_\_\_\_\_

### MEDICAL TREATMENT WITHIN THE PAST FIVE YEARS

DATE	Name of Physician Consulted	Reason

**APPLICANTS DECLARATION** *(An applicant declaring false information is liable to refusal of licence, or licence being cancelled, Tribunal action and monetary fines may apply).*

*I hereby certify that all statements and answers provided by myself in this examination form are complete and true to the best of my knowledge, they are complete and correct, and that I have not withheld any relevant information or made any misleading statement.*

\_\_\_\_\_  
 SIGNATURE OF APPLICANT

\_\_\_\_\_  
 DATE

**NOTES FOR EXAMINERS**

**VISION TESTS**

Squint - Vertical or horizontal obvious or become obvious eye is covered.  
 Eye fixed on examiner. Peripheral vision to hand movement either eye separately.  
 Use Snellen's type at 6 metres  
 EG: A - 6/6 eye readings  
 D - 6 line at 6 metres or D = 3 lines at 3 metres  
 A - 6/9 eye readings  
 D - 9 line at 6 metres or D = 4.5 lines at 3 metres

**CONTACT LENSES**

If this examination is the first wearing of contact lenses a report from the ophthalmologist is required, stating their 1. Stability 2. Duration of daily use and 3. Suitability for Drag Racing.

**IMPORTANT:** IF SIGNIFICANT ABNORMALITIES ARE FOUND PLEASE OBTAIN SPECIALIST OPINION OR PATHOLOGY AS INDICATED AND RETURN WITH THIS FORM.

**MEDICAL PHYSICAL REPORT - CONFIDENTIAL**

Patient Name: \_\_\_\_\_

D.O.B \_\_\_\_\_ Height (cm) \_\_\_\_\_ Weight (kg) \_\_\_\_\_

**Cardiovascular System**

Pulse Rate? (MAX 100) \_\_\_\_\_ Are the peripheral pulses abnormal?  Yes  No  
 Is the rhythm abnormal?  Yes  No Is there any evidence in the history or examination of past or present ischaemic heart disease?  Yes  No  
 Blood Pressure? (MAX 150/90) \_\_\_\_\_ / \_\_\_\_\_

**Respiratory System**

Is there any abnormality of the respiratory system?  Yes  No Is the patient a smoker?  Yes  No

**Abdomen**

Any abnormality?  Yes  No

**Urine**

Albumen  Yes  No  
 Sugar  Yes  No

**Diabetes**

Does the patient have diabetes  Yes  No

**If "YES" Complete the following**

Controlled by  Tablet  Insulin  
 Compliant with medication  Yes  No

**CNS (Central Nervous System)**

Sedative or tranquiliser drugs?  Yes  No

Any abnormality?  Yes  No

**ENT (Ear - Nose - Throat)**

Vestibular System  Yes  No

Any abnormality?  Yes  No

**Vision**

Eyes - any abnormalities?  Yes  No

Eye movements - cover test  Yes  No

Fields - Confrontational test  Yes  No

Visual Acuity	RIGHT	LEFT
NATURAL SIGHT	6 /	6 /

**WITH CORRECTION**

Spectacles  Yes  No  
 Contact Lenses  Yes  No

RIGHT	LEFT
6 /	6 /

**EXAMINERS COMMENTS**

On History \_\_\_\_\_

On Examination \_\_\_\_\_

**\* In your opinion, is the applicant fit to participate in motor sport?**  Yes  No

**STATEMENT BY REGISTERED GENERAL PRACTITIONER**

The applicant was examined on:   =   =

Examiner's Signature

Applicant's Photo ID sighted?  Yes  No

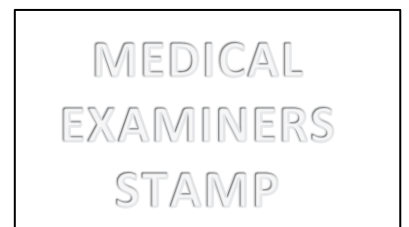
Are you the applicant's normal GP?  Yes  No

Name of medical examiner: \_\_\_\_\_

Address of medical examiner: \_\_\_\_\_

Suburb: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

\_\_\_\_\_



MEDICAL INVALID WITHOUT STAMP