Medical Evaluation Form

Please Keep a Copy

https://nasaproracing.com/account/uploads medicals@drivenasa.com

This four 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 upload this document to the NASA website or to forward it to NASA National.

Any blank spaces will delay license processing!

Memorandum to Examining Physician:

The four 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 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. **Your recommendation for approval will be reviewed, but it is the final decision of the NASA Medical Director** whether or not an applicant is medically cleared for racing. At a minimum, the conditions listed on page three will require review by the Medical Director.

Page One—Background Information for the Medical Evaluation form.
Page Two—Medical History is to be completed by the applicant, and reviewed and initialed by the examiner.
Page Three—Examination is to be completed by a MD/DO or an NP/PA with an MD/DO co-signature.
Page Four—Comments and Recommendations Any requested or necessary additional information and final recommendation—signed by the examiner and supervising physician if NP/PA examiner.

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 130 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: All consultants must be made aware of the information in **Section A & B** of this memorandum.

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 and other parameters as set forth by NASA. **A baseline (one-time) 12-lead EKG tracing must be submitted for all drivers age 45 or greater. Additional EKG tracings shall be at the discretion of NASA by individual request.**

Renewal Intervals (minimum intervals without abnormalities):

***Exceptions:** Medical clearance may be granted in certain circumstances with the approval of the NASA Medical Director. NASA will stipulate any additional requirements or modified/shortened renewal intervals.

Applicants that are less than 40 years old must renew their Medical Evaluation every five years.
Applicants that are at least 40 years old must renew their Medical Evaluation every three years.
Applicants that are at least 50 years old must renew their Medical Evaluation every two years.
Applicants that are at least 70 years old must renew their Medical Evaluation every 12 months.

Reviewed: _____ Applicant's Initials

Reviewed: _____ Examiner's Initials

Applicant's Medical History

(To be completed by applicant and cosigned by MD/DO even if reviewed by PA/NP)

Applicant: For the purpose of obtaining a NASA Competition License, complete this page legibly and in its entirety. Failure to complete the information will delay processing of your license. The examining physician must cosign this page. **Note- the answer of "yes" for any condition highlighted below MUST have a comment on page 4, and may be cause for review and requests for further evaluation/testing by the NASA Medical Director.**

Name:_____ Member #: _____ 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:_____

PLEASE INDICATE IF YOU EVER HAD, OR HAVE NOW, ANY OF THE FOLLOWING
(All "yes" answers require explanation on Page 4):

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/ Pacer/ AICD		
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 NASA, SCCA, BMWCCA, PCA 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 NASA, SCCA, BMWCCA, PCA, or other sanctioning body due to medical reasons		

Date of last Tetanus_____ Blood Type_____

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 injuries on page 4.

I certify that the above is true and correct information. I give my permission for the NASA administration 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 NASA if there is any change in my medical condition.

Affirmed:_____ _____ **Reviewed:** _____ _____

Applicant Signature Date PA/NP Examiner Initials Physician Initials

Examination

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!

Examiner: There are Four PAGES to this form. Please review and sign all 4 pages. Use the fourth page for any explanations, comments, additional history, and recommendations.

Applicant's Name:_____ Birthdate:_____ Age:_____ Sex:_____

Hair Color:_____ Eye Color:_____ Height:_____ Weight:_____

Drivers having the following Conditions must be referred to the NASA Medical Director for review:

Less than 20/40 corrected vision in the better eye	History of Syncope or loss of consciousness	Psychological problems
Loss of color vision (basic flag colors)	Epilepsy	Implanted Defibrillator
Blood pressure: Diastolic over 90, systolic over 160	All gross deformities including loss of extremity or eye or neurological deficits	History of any cardiac problem
Diabetes	Alcoholic or drug addiction	Any examiner concern

Blood Pressure: _____ Pulse:_____ Respirations:_____ (If Hx. COPD: Room Air Pulse Oximetry:_____)

METABOLIC: *History of diabetes: _____No ____Yes If yes, HgbA1C (less than 10)_____*

CARDIAC: *Cardiac Exam: ____Normal ____Murmur ____Irregular*

A baseline 12-lead EKG must be submitted at age 45 for all drivers. Any driver with a history of Diabetes, Heart Disease, Hypertension, or abnormal EKG must submit an EKG beginning at age 30, with subsequent EKG's as requested by NASA.

NEUROLOGICAL:

Examined item	Normal	Abnormal		Examined item	Normal	Abnormal
Cerebellar				*Reflexes*		
Cranial Nerves				*Sensation*		
Cognition				*Strength*		

VISION:

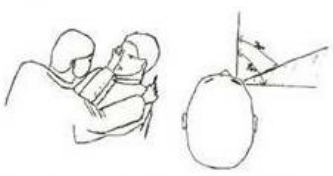
Vision (use numbers) Right:_____ Left:_____Both:_____

Color Vision: _____ Test Used: _____ (Solid flag color recognition is acceptable—green,yellow,red,blue,vs.black)

Peripheral Vision (use numbers) degrees from midline: OD: _____OS: _____Test Used: _____

Tips On Peripheral Vision Exam

Peripheral vision exam by confrontation is a simple procedure. Position yourself so that your face is directly in front and on the same level with the patient, about 2 feet away. Ask the patient to cover one eye and to look at your eye directly opposite. Close your other eye so that your own visual field is roughly superimposed on that of the patient. Bring a pencil or other small object (light) from behind and from the periphery slowly into the patient's field of vision. Ask the patient to indicate when the object appears. Estimate in degrees the point where the patient sees the object to the point where the patient is looking directly ahead. Test the other eye in the same manner. Lack of adequate or impaired peripheral vision should be given special consideration.



Reviewed: **Exam Completed and Reviewed By:**

_____	_____	_____	_____
Applicant Initials	PA/NP Examiner Signature	Physician Signature	Date

Additional History or Comments

(Place comments to all "Yes" answers from Page 2 here as well any other additional information regarding the history or examination)

RACING is a very physically demanding sport.
Please perform your evaluation and recommendation with that in mind.

Based on review of all 4 pages I RECOMMEND (acknowledging that NASA has the final decision):

☐	**The Applicant appears fit for competition automobile racing**
☐	**The Applicant appears fit, but I would like (or above rules require) his/her paperwork to be reviewed by the Medical Director**
☐	**The applicant is not cleared by me for automobile racing (Please fax or e-mail immediately to 510-277-0657, medicals@drivenasa.com)**

PA/NP Examiner _____

Address_____

City _____ State_____ Zip_____

Phone Number _____

Reviewed:

Physician _____

Address _____

City_____ State_____ Zip_____

Phone Number _____

Reviewed:

Applicant Initials _____ PA/NP Examiner Signature _____ Physician Signature _____ Date _____

(Supervising M.D. or D.O. Physician Co-signature Required for all PA/NP Evaluations)