



Physican's Examination and Medical History Forms

Dear Doctor,

You are being asked to examine this applicant for the purpose of obtaining a competition racing license issued by the BMW Car Club of America (BMW CCA) Club Racing. This form concentrates on the organ system(s) and disease processes that may jeopardize the applicant or others attending competition race events.

The functional requirements of a driver in a competition automobile are:

1. Ability to rapidly operate acceleration, braking and steering mechanisms/systems (mechanical assistance allowed).
2. Vision: distant vision correctable to 20/40 each eye, ability to distinguish basic colors (red, green & yellow), and peripheral vision to 45 degrees in the horizontal median for each eye.
3. Minimal chance of sudden incapacitation from any disease process.
4. Ability for rapid mental activity and problem solving.

The environment this applicant may operate in is:

1. Temperature extremes from 0 to 120 degrees external to the vehicle (hotter inside).
2. Smoke, fumes, vapor, and dust.
3. Noise, and vibration.
4. Potential for the presence of fire.

Any place where consults are needed, the consultant must have a significant knowledge of the disease process and the high speed racing environment.

Applicants who have not received a medical waiver are required to submit a current physical examination:
every five (5) years for those 16 - 39 years of age
every three (3) years for those 40 - 49 years of age
every two (2) years for those 50 - 59 years of age
each year for those 60 years of age and older

Requirements for applicants who have received a medical waiver are defined by the BMW CCA Club Racing Medical Committee.

Thank you for your input.

Sincerely,

The BMW CCA Club Racing Medical Committee

Attachment



APPLICANT'S MEDICAL HISTORY (To be completed by applicant)

Applicant: For the purpose of obtaining a BMW CCA Club Racing License, complete this page legibly and in its entirety. Failure to complete required information will delay the processing of your license. Examining Physician must complete page two of this form.

Name: _____ Age: _____ Date of Birth: _____

Address: _____ City, St. Zip: _____

Your Personal Physician: _____ Phone: () _____

Address: _____ City, St. Zip: _____

Have you been treated for, have you ever had, or have you now, any of the following:
(Yes responses should be explained on a separate sheet and attached when submitted)

Conditions	Yes	No
Diabetes: Insulin required		
Unconsciousness for any reason		
Dizziness or fainting spells		
Epilepsy or Seizures		
Heart Trouble: Coronary Artery Disease or Angina Valve disease Left Bundle Branch Block Abnormal Cardiac Rhythms		
High Blood Pressure		
Any drug, narcotic or alcohol problems		
Psychiatric/Mental Health Problems		
Operation(s) involving Eyes, Brain, Heart, Nerves, Blood Vessels, or Bones		
Previous waiver(s) from BMW CCA Club Racing for a medical condition: List:		
Amputation/Physical disability		

Conditions	Yes	No
Eye trouble (except glasses)		
Cancer (last 5 years)		
Anemia, or other blood diseases including abnormal bleeding		
Admission to a hospital in the past 12 months. Why?		
Allergy(s) to medications List:		
Previous denial(s) from BMW CCA Club Racing due to a medical reason(s) List:		
Illness(s) not mentioned above List:		

Date of last Tetanus: _____

Blood Type (if known): _____

Comments: _____

Medications Used (including eye drops):

This is to certify that these statements are true and accurate. I also give permission to any hospital, institution, or physician, to furnish any information to the BMW CCA Club Racing Medical Committee.

Applicant's Signature: _____ **Date:** _____

PHYSICIAN'S EXAMINATION

(To be completed by a Medical Doctor)

Applicant's Name: _____ Age: _____

NOTE: Candidates having the following afflictions must be referred to the BMW CCA Club Racing Medical Committee for review:

- | | | |
|---|---|--------------------------------|
| 1. Less than 20/40 corrected vision in the better eye | 4. All gross deformities subject to listing | 8. Psychological problems |
| 2. Alcoholic or drug addiction | 5. Loss of extremity or eye | 9. Epilepsy |
| 3. Blood pressure: Diastolic over 90, systolic over 160 | 6. Diabetes | 10. History of Heart Attack |
| | 7. Loss of color vision | 11. History of Cardiac Disease |
| | | 12. Loss of consciousness |

EKG's need to be completed and attached for the following conditions:

- | | | |
|-------------------------------|---|--|
| 1. Abnormal EKG | 4. Hypertension/Blood Pressure | 5. Diabetes |
| 2. Smoker | a) reading > 140 systolic or 90 diastolic | a) Insulin – required annual |
| 3. History of Cardiac Disease | b) treated by physician – every 5 years | b) Non insulin – required per medical exam group |

Abnormalities require an attached Ophthalmological, Neurological or Cardiologic consult

Blood Pressure: _____ Pulse: _____ Respiration: _____ Height: _____ Weight: _____
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VISION <i>Abnormalities refer to above.</i> Vision (use numbers) Right: _____ Left: _____ Both: _____ Color Vision "You can see.." (Red: ____ Yes ____ No) (Green: ____ Yes ____ No) (Yellow: ____ Yes ____ No) Peripheral Vision (use numbers) degrees from midline: _____ Right: _____ Left: _____ Test: _____
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NEUROLOGICAL <i>Abnormalities refer to above.</i> Reflexes: ____ Normal ____ Abnormal Other tests performed: _____ _____
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CARDIAC <i>Abnormalities refer to above.</i> Cardiac Exam: ____ Normal ____ Abnormal
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METABOLIC <i>Please attach a HgbA1C for Diabetic</i> Diabetic: ____ Yes ____ No Insulin: ____ Yes ____ No HgbA1C (less than 10) _____ Evidence of end organ damage: ____ Yes ____ No

Comments or concerns that the BMW CCA Club Racing Medical Committee should be aware of: _____

Comments regarding current medications the applicant is taking (any side effects): _____

Examining Physician's Comments regarding applicants medical history: _____

<p>On the basis of this limited examination, review of the patient's history, and the instructions addressed to me, I (check one):</p> <p>____ Recommend that this examinee be considered for medical approval to participate in high speed automotive competition events.</p> <p>____ Recommend that this examinee's medical information be reviewed by the BMW CCA Club Racing Medical Committee.</p> <p>Physician Signature and Stamp: _____ Phone: (____) _____</p> <p>Signed: _____ Date: _____</p>
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