



AUSTRALIAN NATIONAL DRAG RACING ASSOCIATION INC.

ABN 25 886 224 815

MEDICAL EXAMINATION RECORD

APPLICANT DETAILS

**PLEASE COMPLETE ALL SECTIONS WITHIN THE DARK LINE
PRIOR TO SEEING YOUR DOCTOR (PLEASE PRINT)**

SURNAME

FIRST NAMES

ADDRESS IN FULL

POSTCODE

CONTACT DETAILS

BUSINESS _____

PRIVATE _____

MOBILE _____

EMAIL _____

OCCUPATION

TYPE OF VEHICLE TO BE DRIVEN

OFFICE USE ONLY

MEDICAL DETAILS TO BE ENTERED ON
LICENCE

GLASSES

CONTACT LENSES

ASSESSOR'S SIGNATURE

PREVIOUS ANDRA LICENCE

YEAR:

NUMBER:

1. STATEMENT BY APPLICANT

Have you, or are you suffering from –

- 1.1 Any nervous disorder including nerves, neurasthenia or anxiety state?
- 1.2 Headaches?
- 1.3 Fits or convulsions, turns or blackouts, fainting or giddiness?
- 1.4 Head injury or concussion?
- 1.5 Tuberculosis or other lung trouble?
- 1.6 Rheumatic fever or heart disease?
- 1.7 Indigestion, gastric or duodenal ulcer?

ANSWER
YES OR NO

- 1.1.....
- 1.2.....
- 1.3.....
- 1.4.....
- 1.5.....
- 1.6.....
- 1.7.....

- 1.8 Kidney or bladder trouble?
- 1.9 Diabetes?
- 1.10 Anaemia or any other blood disease?
- 1.11 Deafness or noise in the ear?
- 1.12 Earache or discharge from the ear?
- 1.13 Chronic sinusitis?
- 1.14 Any surgical operations?
- 1.15 Any injury?
- 1.16 Any illness not already mentioned?
- 1.17 Are you taking any injections, tablets or other forms of medication?

- 1.8.....
- 1.9.....
- 1.10.....
- 1.11.....
- 1.12.....
- 1.13.....
- 1.14.....
- 1.15.....
- 1.16.....
- 1.17.....

IF "YES" TO ANY OF THE ABOVE QUESTIONS, GIVE FULL DETAILS HERE.

APPLICANT'S DECLARATION (An applicant making a false declaration is liable to refusal or cancellation of licence)

I hereby declare that I have carefully considered the statements made above, and that, to the best of my belief, they are complete and correct, and that I have not withheld any relevant information or made any misleading statement. Furthermore I declare that, should any of the above conditions become evident during the currency of this licence, I agree to abstain from exercising the privileges of this licence, and to notify the ANDRA Medical Assessor and submit myself for further medical examination, the results of which will be forwarded to him or her.

I hereby give my full authority the ANDRA Medical Assessor to obtain information from relevant Clinical Records, X-Ray and Pathology Reports from any Medical Officer I have previously attended. **NB: (Female Applicants Only):** I agree to abstain from exercising the privileges of this Licence while in the last four months of Pregnancy. A fee of \$5.50 (inc GST) will be charged in the event that any additional correspondence is required occasioned by incomplete or incorrect applications.

SIGNATURE OF APPLICANT (OR GUARDIAN OR REPRESENTATIVE IF APPLICANT IS A MINOR)

SIGNATURE OF MEDICAL EXAMINER AS WITNESS

DATE

NAME/ADDRESS OF GUARDIAN OR REPRESENTATIVE WHERE APPLICABLE (PLEASE PRINT)

NOTES FOR EXAMINERS

IMPORTANT:

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

NOTES ON VISION TESTS (12)

- | | |
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| <p>12.2 Squint – vertical or horizontal obvious or becomes obvious when either eye is covered.</p> <p>12.3 Eye fixed on examiner. Peripheral vision to hand movements – either eye separately.</p> | <p>12.4 Use Snellen's type at 6 metres
e.g. A - 6/6 eye readings
D=6 line at 6 metres
D=3 line at 3 metres</p> <p>or</p> <p>A – 6/9 eye readings
D=9 line at 6 metres
D=4.5 line at 3 metres</p> |
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CONTACT LENSES

If this examination is the applicant's 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 motor racing activities.

MEDICAL REPORT - CONFIDENTIAL

2. AGE	3. HEIGHT	4. WEIGHT	5. ANY DEFORMITY or limitation of movement	
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<p>6. CVS</p> <p>6.1 Pulse rate</p> <p>6.2 Rhythm</p> <p>6.3 Blood Pressure e.g. 120/70</p> <p>6.4 Any hypotension or other CVS drugs in use?</p> <p>6.5 Any CVS abnormality?</p>	<p>8. URINE</p> <p>8.1 Albumen</p> <p>8.2 Sugar</p> <p>9. ABDOMEN</p> <p>Any abnormality?</p> <p>10. CNS</p> <p>10.1 Sedative or tranquiliser drugs?</p> <p>10.2 Any abnormality?</p> <p>11. ENT</p> <p>11.1 Vestibular system?</p> <p>11.2 Any abnormality?</p>
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<p>7. RESPIRATORY SYSTEM</p> <p>7.1 Any antihistamine or other respiratory drugs in use?</p> <p>7.2 Any abnormality</p>	<p>12. VISION</p> <p>12.1 Eyes – any abnormalities?</p> <p>12.2 Eye movements Cover Test</p> <p>12.3 Fields Confrontational Test</p>
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<p>12.4 Visual Acuity</p> <p>NATURAL SIGHT</p> <p>WITH CORRECTION</p> <p>SPECTACLES <input type="checkbox"/> Tick <input type="checkbox"/> Appl. CONTACT LENSES <input type="checkbox"/> Box</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">RIGHT</td> <td style="width: 50%;">LEFT</td> </tr> <tr> <td>6/</td> <td>6/</td> </tr> <tr> <td>6/</td> <td>6/</td> </tr> </table>	RIGHT	LEFT	6/	6/	6/	6/
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EXAMINERS COMMENTS

On History	
On Examination	
Is there anything unfavourable in the applicant's personality revealed by history, appearance or behaviour?	
IN YOUR OPINION IS THE APPLICANT FIT TO TAKE PART IN MOTOR RACING ACTIVITIES? YES / NO	

STATEMENT BY MEDICAL EXAMINER:

I have personally examined this applicant on this day.

Signature

Date

NB: MEDICAL EXAMINER MUST ALSO WITNESS APPLICANT'S STATEMENT ON FRONT PAGE OF THIS FORM

Please forward completed form to :

**THE MEDICAL ASSESSOR
ANDRA HEAD OFFICE
PO BOX 250 KENT TOWN SA 5071**

Examiner's Name & Address (block letters or stamp)