INTERNATIONAL HOT ROD ASSOCIATION
1555 PALM BEACH LAKES BLVD. SUITE 400
WEST PALM BEACH, FLORIDA, 33401
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MEDICAL PHYSICAL FORM

(NOTE – PHYSICALS ARE GOOD FOR 2 YEARS FROM THE DATE OF THE PHYSICIANS SIGNATURE)

Name: ______________________________ Date of Birth: ________________________

Address: ____

City: ______________________________ State: _____________ Zip: ________________

Signature: ____________________________________ Date: _______________________

MEDICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING: (For each "yes" checked describe conditions in remarks)

Y	N	CONDITION	Y	N	CONDITION	Y	N	CONDITION	Y	N	CONDITION
		a. frequent or severe headaches			g. heart trouble			m. nervous trouble of any sort			s. medical rejection from service
		b. dizziness or fainting spells			h. high or low blood pressure			n. any drug or narcotic habit			t. admission to hospital
		c. unconsciousness for any reason			i. stomach trouble			o. excessive drinking habit			u. rejection for life insurance
		d. eye trouble except glasses			j. kidney stone or blood in urine			p. attempted suicide			v. record of traffic convictions
		e. hay fever			k. sugar or albumin in urine			q. motion sickness requiring drugs			w. record of other convictions
		f. asthma			l. epilepsy or fits			r. military medical discharge			x. other illnesses

REMARKS: (if no changes since last report, so state) ____

MEDICAL TREATMENT WITHIN THE PAST FIVE YEARS

Date	Name of Physician Consulted	Reason

____________________________________ ____________________
SIGNATURE OF APPLICANT DATE

APPLICANTS' DECLARATION: ***I hereby certify that all statements and answers provided by me in this examination form are complete and true to the best of my knowledge. I agree that they are to be considered part of the basis for insurance of any IHRA certificate to me.***

REPORT OF MEDICAL EXAMINATION

NORMAL	ABNORMAL	CHECK EACH ITEM IN APPROPRIATE BOX
		1. Head, face, neck and scalp
		2. Nose
		3. Sinuses
		4. Mouth and throat
		5. Ears, general (internal and external canals)
		6. Ear Drums (perforation)
		7. Eyes, general (visual activity under items 50 &51)
		8. Ophthalmoscopic
		9. Pupils (equality and reaction)
		10. Ocular mobility (associated parallel movement, mystaginus)
		11. Lungs and chest (including breasts)
		12. Heart (thrust, size, rhythm, sounds)
		13. Vascular system
		14. Abdomen and viscera (including hernia)
		15. Endocrine system
		16. G-U system
		17. Upper and lower extremities (strength, range of motion)
		18. Spine other musculoskeletal
		19. Skin and lymphatic
		20. Neuralgic (tendon reflexes, equilibrium, senses, coordination)
		21. Psychiatric (specify any personality deviation)
		22. General Systemic

NOTES: Describe every abnormality in detail, enter applicable item number before each comment. Use additional sheets if necessary and attach to this form.

Corrective lens required while driving		FIELD OF VISION	DISTANT VISION		NEAR VISION
[ ] NO * if previously "yes", please include explanation of change	**[ ] YES**	**[ ] Normal**	**Right eye**	**20/**	**20/**
		[ ] Abnormal	**Left eye**	**20/**	**20/**
			Both eyes	**20/**	**20/**

FIELD OF VISION	
RIGHT EYE	LEFT EYE

BLOOD SUGAR TEST
(both fasting and 2 hour post prandial, required only if sugar is found in urine No S.I. Units))

FASTING	2-HOUR P.P.	HgA 1C	COMMENTS

BLOOD PRESSURE		
Recumbent MM Mercury	Systolic	Diastolic

PULSE (Wrist)		
Resting	After Exercise	2 minutes after exercise

URINALYSIS	
Albumen	Sugar

OTHER TESTS

DISQUALIFYING DEFECTS/LIMITATIONS:

COMMENTS ON HISTORY AND FINDINGS:

APPLICANTS NAME:

FURTHER EVALUATION REQUIRED (EXPLAIN):

[ ] PHYSICALLY ACCEPTABLE

MEDICAL EXAMINER'S DECLARATION: I hereby cerify that I personally examined the applicant named on this medical examination repot, and that this report and any attachment embodies my findings completely and correctly.

EXAMINATION DATE	MEDICAL EXAMINER'S NAME AND ADDRESS	MEDICAL EXAMINER'S SIGNATURE