Examination and Medical History Forms

Please Keep a Copy

Examination form to be completed by examiner (MD, DO, PA-C or NP) and returned to the applicant. Must be completed between July 1, 2019 and August 29, 2020.

Due to PPIHC by August 1, 2020.

Memorandum to Examining Physician:

This form is a guide and tool for you to determine if this competitor is medically qualified to race. This form concentrates on the conditions and disease processes that may jeopardize the competitor or others while attending a competitive racing event.

Page One (this page) - Instructions for completing the Physical Examination form. This page should be read carefully by both the examining physician and the competitor.

Page Two - Examination is to be completed by a Physician.

Page Three - Medical History is to be completed by the Competitor prior to the Examination.

A. The functional suggested requirements of a driver or rider, in or on a competition vehicle, are:

1. Ability to rapidly operate acceleration, braking, and steering mechanisms/systems.
2. Ability to visually distinguish basic colors. Vision: distant vision correctable to 20/40 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 includes:

1. Extended exposure (4-6 hours) at high elevation (9,000 – 14,115 feet) (2,743 – 4,302 meters) above sea level.
2. Temperature extremes from 30 degrees (F) to 90 degrees (F).
3. Smoke, fumes, vapors and caustic chemicals.
4. Increased potential for exposure to fire.
5. Loud noise and vibration.

Examination

To be completed by a MD, DO, PA-C or NP only.
Examination must be completed between July 1, 2019 and August 29, 2020.

Applicant's Name:_____ Date:_____ Blood Type: _____

Age:_____ Sex:_____ Hair Color:_____ Eye Color: _____

Blood Pressure:_____ Pulse:_____ Respiration:_____ Weight:_____ Height: _____

NEUROLOGICAL

Reflexes:_____Normal_____Abnormal

Other tests performed: _____

CARDIAC

Cardiac Exam:_____Normal _____Abnormal

Notes:_____

METABOLIC

History of diabetes:_____No_____Yes

if yes then HgbA1C level recommended

HgbA1C (less than 10) _____

VISION

Vision (use numbers 20/20) OD (Right):_____/_____ OS (Left):/_____ OU (Both):_____/_____

Color Vision:_____Test:_____

Medical conditions to consider in the decision to approve this candidate

1. Less than 20/40 corrected vision in the better eye
2. Alcohol or drug addiction
3. Blood pressure: Diastolic over 90, Systolic over 160
4. All gross deformities subject to listing
5. History of Syncope
6. Loss of extremity or eye
7. Diabetes
8. Loss of consciousness
9. Psychological problems
10. Implanted Defibrillator
11. Limitations of endurance in any activities of daily living (i.e. climbing 2-3 flights of stairs without stopping)
12. Epilepsy
13. History of Heart Attack
14. History of Cardiac Disease
15. Use of Narcotics
16. Reduced pulmonary capacity (includes the need for supplemental oxygen.)

RACING is a physically demanding sport.

Perform your examination and determination with that in mind.
In the event the applicant fails, an appeals process exists.
Please contact PPIHC with any questions at 719-685-4400.

APPROVED

Medical history and examination approved.
Applicant is fit for motor racing.
A copy of this examination is on file at my office.

Physician Signature _____

Printed Name _____

Address _____

City_____State____Zip_____Country____

Date_____ Phone Number_____

FAILED

Applicant is not fit for motor racing.
A copy of this examination is on file at my office.

Physician Signature _____

Printed Name _____

Address _____

City_____State____Zip_____Country _____

Date_____Phone Number_____

Please return to: Pikes Peak International Hill Climb – 1631 Mesa Ave. Suite E, Colorado Springs, CO 80906 E-Mail: alex@ppihc.org

Competitor's Medical History

(To be completed by Competitor)

Competitor: Complete this page legibly and in its entirety. Failure to complete the information will delay processing. Your examining physician must complete the second page of this form.

Name:_____ Age:_____ Date of Birth: _____

Address:_____ City, St, Zip: _____

Country:_____ Occupation: _____

Phone: (Cell)_____ Email Address:_____

Personal Physician:_____ Phone: _____

Address:_____ City, St, Zip: _____

PLEASE INDICATE IF YOU EVER HAD, OR HAVE NOW, ANY OF THE FOLLOWING:

Do You Have or Have You Ever Had?	Yes	No
Frequent or severe headaches		
Head or spinal injuries		
Unconsciousness for any reason		
Dizziness or fainting spells		
Epilepsy or seizures		
Coronary artery disease or angina		
Heart valve disease		
Left Bundle Branch Block (heart)		
Abnormal cardiac rhythms		
High Blood pressure		
Operation(s) on brain		
Operation(s) on heart		
Operation(s) on eyes, nerves, blood vessels, or bones		
Respiratory Disease		

Do You Have or Have You Ever Had?	Yes	No
Any drug, narcotic, or alcohol problems		
Psychiatric/mental health problems		
Eye trouble (except glasses)		
Asthma		
Diabetes requiring insulin		
Anemia or other blood diseases, including abnormal		
Admission to a hospital in the past 12 months for any reason		
Allergy(s) to medications List:		
Routine use of Pain Medication		
Amputations/physical disability		
Illness(es) not listed above List:		

A. Comments and details of any condition noted above and/or list of medication(s) used(including eye drops) _____

_____

_____

_____

_____

Competitor Signature:_____ Date:_____