IHRA NEW ZEALAND
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G1 MEDICAL PHYSICAL FORM

NOTE: PHYSICAL ARE GOOD FOR 2 YEARS FROM THE DATE OF PHYSICIAN'S SIGNATURE

Medical Examination Record Applicable to IHRA Australia licence holder ONLY
(must be completed by a Medical Practitioner registered to practice medicine in Australia)

Surname		Given Names	
Address			
Suburb		State/Postcode	
Phone		Mobile	
D.O.B.		Male / Female	

The following section is to be completed by applicant PRIOR to seeing your Medical Practitioner

MEDICAL HISTORY

Have you ever had any of the following (for each "YES" checked describe conditions in Remarks below)

Y	N	CONDITIONS	Y	N	CONDITIONS
		Frequent or severe headaches			Motion sickness
		Dizziness or fainting spells			Earache or discharge from ear
		Indigestion, gastric or duodenal ulcers			High or Low blood pressure
		Kidney stone or blood in urine			Asthma
		Diabetes			Admission to hospital
		Sugar or albumen in urine			Any illness not already mentioned?
		Epilepsy or fits			Are you taking any prescribed medications?
		Heart trouble			

Remarks: _____

MEDICAL TREATMENT WITHIN THE PAST FIVE YEARS

DATE	Name of Physician Consulted	Reason

APPLICANTS DECLARATION *(An applicant declaring false information is liable to refusal of licence, or licence being cancelled, Tribunal action and monetary fines may apply).*

I hereby certify that all statements and answers provided by myself in this examination form are complete and true to the best of my knowledge, they are complete and correct, and that I have not withheld any relevant information or made any misleading statement.

SIGNATURE OF APPLICANT _____ DATE _____

NOTES FOR EXAMINERS

VISION TESTS

Squint - Vertical or horizontal obvious or become obvious eye is covered.
Eye fixed on examiner. Peripheral vision to hand movement either eye separately.
Use Snellen's type at 6 metres

EG: A - 6/6 eye readings
D - 6 line at 6 metres or D = 3 lines at 3 metres
A - 6/9 eye readings
D - 9 line at 6 metres or D = 4.5 lines at 3 metres

CONTACT LENSES

If this examination is the 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 Drag Racing.

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

MEDICAL PHYSICAL REPORT - CONFIDENTIAL

Patient Name:

D.O.B | Height (cm) | Weight (kg)

Cardiovascular System

Pulse Rate? (MAX 100)

Is the rhythm abnormal? ☐ Yes ☐ No

Blood Pressure? (MAX 150/90) _____ / _____

Are the peripheral pulses abnormal? ☐ Yes ☐ No

Is there any evidence in the history or examination of past or present ischaemic heart disease? ☐ Yes ☐ No

Respiratory System

Is there any abnormality of the respiratory system? ☐ Yes ☐ No

Is the patient a smoker? ☐ Yes ☐ No

Abdomen

Any abnormality? ☐ Yes ☐ No

Urine

Albumen ☐ Yes ☐ No

Sugar ☐ Yes ☐ No

Diabetes

Does the patient have diabetes ☐ Yes ☐ No

If "YES" Complete the following

Controlled by ☐ Tablet ☐ Insulin

Compliant with medication ☐ Yes ☐ No

CNS (Central Nervous System)

Sedative or tranquiliser drugs? ☐ Yes ☐ No

Any abnormality? ☐ Yes ☐ No

ENT (Ear - Nose - Throat)

Vestibular System ☐ Yes ☐ No

Any abnormality? ☐ Yes ☐ No

Vision

Eyes - any abnormalities? ☐ Yes ☐ No

Eye movements - cover test ☐ Yes ☐ No

Fields - Confrontational test ☐ Yes ☐ Yes

Visual Acuity

	RIGHT	LEFT
NATURAL SIGHT	6 /	6 /

WITH CORRECTION

			RIGHT	LEFT
Spectacles	☐ Yes	☐ No		
Contact Lenses	☐ Yes	☐ No	6 /	6 /

EXAMINERS COMMENTS

On History

On Examination

In your opinion, is the applicant fit to particapte in motor sport? ☐ Yes ☐ No ☐ Further Assessment

Statement by Registered General Practitioner

The applicant was examined on: ☐☐ – ☐☐ – ☐☐

Applicant's Photo ID sighted? ☐ Yes ☐ No

Are you the applicant's normal GP? ☐ Yes ☐ No

Name of medical examiner:

Address of medical examiner:

Suburb: State: Postcode:

Examiner's Signature

MEDICAL EXAMINERS STAMP

MEDICAL INVALID WITHOUT STAMP