



INTERNATIONAL HOT ROD ASSOCIATION
 P.O. Box 386
 House Springs, MO 63051
 Phone: 85.JOIN.IHRA (855.646.4472) | Email: info@ihra.com

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

Corrective lens required while driving	FIELD OF VISION	DISTANT VISION	NEAR VISION					
<input type="checkbox"/> NO * if previously "yes", please include an explanation of the change	<input type="checkbox"/> YES	<input type="checkbox"/> Normal	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">Right eye</td> <td style="width: 25%;">20/</td> <td style="width: 25%;">20/</td> </tr> </table>	Right eye	20/	20/		
	Right eye	20/	20/					
		<input type="checkbox"/> Abnormal	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">Left eye</td> <td style="width: 25%;">20/</td> <td style="width: 25%;">20/</td> </tr> <tr> <td style="width: 25%;">Both eyes</td> <td style="width: 25%;">20/</td> <td style="width: 25%;">20/</td> </tr> </table>	Left eye	20/	20/	Both eyes	20/
Left eye	20/	20/						
Both eyes	20/	20/						

FIELD OF VISION		BLOOD SUGAR TEST (both fasting and 2 hour post prandial, required only if sugar is found in urine No S.I. Units))			
RIGHT EYE	LEFT EYE	FASTING	2-HOUR P.P.	HgA 1C	COMMENTS

BLOOD PRESSURE			PULSE (Wrist)		
Recumbent MM Mercury	Systolic	Diastolic	Resting	After Exercise	2 minutes after exercise

URINALYSIS		OTHER TESTS
Albumen	Sugar	

DISQUALIFYING DEFECTS/LIMITATIONS:

COMMENTS ON HISTORY AND FINDINGS:

APPLICANTS NAME: PHYSICALLY ACCEPTABLE	FURTHER EVALUATION REQUIRED (EXPLAIN):
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MEDICAL EXAMINER'S DECLARATION: I hereby certify that I personally examined the applicant named on this medical examination report, 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
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