INTERNATIONAL HOT ROD ASSOCIATION
PO BOX 708 9 ½ EAST MAIN STREET
NORWALK, OHIO 44857
PHONE: 419-663-6666 FAX: 419-668-6601

MEDICAL PHYSICAL FORM

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, and 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. Anus and rectum (hemorrhoids, fistula, prostate)
		16. Endocrine system
		17. G-U system
		18. Upper and lower extremities (strength, range of motion)
		19. Spine other musculoskeletal
		20. Identifying body marks, scar, tattoos
		21. Skin and lymphatic
		22. Neuralgic (tendon reflexes, equilibrium, senses, coordination)
		23. Psychiatric (specify any personality deviation)
		24. 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		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		**ECG** (Date)	**OTHER TESTS**
Albumen	Sugar		

DISQUALIFYING DEFECTS/LIMITATIONS:

COMMENTS ON HISTORY AND FINDINGS:

APPLICANTS NAME:	FURTHER EVALUATION REQUIROED (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