



## MEDICAL HISTORY FORM

(To be completed by the Applicant)

### Personal Data

Name		First name	
Address			
Sex	Male/ female	Date of birth	

NO		YES	DETAILS
	Loss of consciousness for any reason, dizziness or headaches		
	Eye problems (except corrective glasses/ contact lenses)		
	Asthma		
	Allergy to medicines or drugs		
	Diabetes		
	Heart problems		
	Blood pressure disorder		
	Stomach problems (ulcer etc)		
	Uro-gential problems		
	Epilepsy or convulsions		
	Mental or nervous disorder		
	Problems with arms or legs including muscle cramps or stiffness		
	Blood disorder with tendency to bleeding		
	Surgical, truatological, medical treatments received		
	Do you take any medicines regularly		

- a) I have not been banned, on medical grounds from taking part in any other sport.  
 b) I do not take drugs and do not abuse alcohol  
 c) In case of an injury I give permission to the medical staff to release any relevant information to the Clerk of the Course, my relatives, my own doctor and the ASN  
 d) I declare that the information that I give is the truth  
 e) I agree to the information on the Medical Examination Form being sent to the doctor of the ASN

Date (dd/mm/yy)	Signature of applicant(or responsible parent or guardian if a minor)
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## MEDICAL REPORT

(To be completed by Doctor)

### Personal Data

Name		First name	
Address			
Sex	Male/ female	Date of birth	

Height	Weight
Date of last tetanus	Blood type

Normal			Abnormal	DETAILS
	Blood pressure			
	Pulse			
	Respiratory system			
To be performed every 2 years- date of previous test:				
	Under 45 years of age: 12 lead electrocardiogram			
	Over 45 years of age: stress test ECG			
Eye sight- For initial application ONLY				
	Distant vision without correction: left			
	Distant vision without correction: right			
	Distant vision with correction: left			
	Distant vision with correction: right			
	Colour vision			
	Visual field			
	Muscoskeletal examination			
	Right arm			
	Left arm			
	Right leg			
	Left leg			
	Spine			
	Abdomen (hernia)			

MEMBER OF



	Urine- Albumen		
	Urine- Glucose		

Date (dd/mm/yy)	Signature and stamp of doctor
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**Applicant's declaration:**

All information given to the doctor regarding my present state of health and previous medical history is correct.

I undertake not to use any substance included in the World Anti-Doping Agency list of prohibited substances and methods.

I undertake to advise the ASN without delay of any significant change in my state of health:

- a) from a medical point of view including any medication being taken for more than three weeks
- b) from a traumatological point of view, whether or not the accident is followed by a period off work and whether or not it is linked to the practice of motorsport.

Date (dd/mm/yy)	Signature of applicant (or responsible parent or guardian if a minor)
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