WORLD KARTING ASSOCIATION®
THE FOUNDATION OF MOTORSPORTS™
www.worldkarting.com 6051 Victory Lane, Concord, N.C. 28027 • P) 704-455-1606 • F) 704.455.1609

Applicant's Medical History

(to be completed by Applicant)

For the purpose of obtaining an International FIA/CIK competition license, please complete this page legibly and in it's entirety. Failure to complete the information will delay processing of your license. The examining physician must compete and sign the Physicians part of this form

Name_______________________________________Age________Date of Birth ____________.

Address_________________________________City, State, Zip____________________________ .

Email Address____________________________Occupation________________________________.

Phone (H)__________________________(W)____________________Cell____________________.

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

Do You have or Have you Ever Had	Yes	No	Do You have or Have you Ever Had	Yes	No
Frequent or severe headaches			Any drug, narcotic, or alcohol problems		
Unconsciousness for any reason			Psychiatric/mental health problems		
Dizziness or fainting spells			Eye trouble (except glasses)		
Epilepsy or seizures			Asthma		
coronary artery disease or angina			Diabetes requiring insulin		
Heart valve disease			Anemia or other blood diseases including abnormal bleeding		
Left bundle Branch Block (heart)			Admission to a hospital in the past 12 months for any reason		
Abnormal cardiac rhythms			Allergy to medications List:		
High Blood Pressure			Routine use of Pain Medications		
Operation on brain			Amputation/Physical disability		
Operation on heart			Illness not listed above		
Operation(s) on eyes, nerves, blood vessels, or bone			Previous denial(s) from other sanctioning body due to medical reasons		
Previous waivers from other sanctioning body due to medical conditions List:					

Blood Thinner Medication (circle) Yes No

Comments and details of any condition noted above. Medication used including eye drops.

____
____
____
____

EXAMINATION

To be completed by a MD, DO, PA-C or NP only.
Any blanks will delay processing
Examination shall not be more than six (6) months old upon license application.

Applicant's Name____Date___________________.

Age ______ Sex_________Hair Color_________Eye Color________ Weight ________________.

Height_________. Blood Pressure____________. Pulse__________.Respiration__________________.

NEUROLOGICAL
Reflexes ______Normal ________Abnormal

CARDIAC
Cardiac Exam_____Normal___Abnormal_______.

METABOLIC (if yes then the HgbA1C level recommended)
History of Diabetes _______yes ________ no HgbA1C (less than 10)________________.

VISION
(use #'s: example 20/20)OD Right Vision _____/______ OS Left Vision _____/______ OU Both _____/______
Color Vision_________ Test______________
Peripheral Vision # of degrees from mid Center__________OD_________OS_________Test________.

Racing is a physically demanding Sport.
Please Perform your exam and determination with that in mind

Medical conditions to consider in the decision to approve candidate

1. Less than 20/40 corrected vision in the better eye
2. Alcoholic 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 eyes
7. Diabetes
8. Los of consciousness
9. Psychological problems
10. Implanted Defibrillator
11. Epilepsy
12. History of Hear Attack
13. History of Cardiac Disease
14. Use of Narcotics

Approved_________.
Medical history & Exam approved
Applicant is fit for racing.

Failed ____________.
Applicant is not fit for racing

Physicians Signature_________________________________.

Printed Name _____________________________________.

Address_______________________________________.

City____________________ State_______ Zip_________.

Phone Number__________________Date______________.