

## MEDICAL EXAMINATION RECORD

Surname	<input style="width: 95%;" type="text"/>	Given Names	<input style="width: 95%;" type="text"/>
Postal Address	<input style="width: 100%;" type="text"/>		
Suburb	<input style="width: 95%;" type="text"/>	State/ Postcode	<input style="width: 95%;" type="text"/>
Email	<input style="width: 100%;" type="text"/>		
Phone: Business	<input style="width: 95%;" type="text"/>	Phone: Mobile	<input style="width: 95%;" type="text"/>
Birth Date	<input style="width: 95%;" type="text"/>	Gender	<input style="width: 95%;" type="text"/>
Type of Vehicle to be driven	<input style="width: 100%;" type="text"/>		
Occupation	<input style="width: 100%;" type="text"/>		

**PLEASE COMPLETE ALL SECTIONS ON THIS PAGE PRIOR TO SEEING YOUR DOCTOR (PLEASE PRINT)**

### 1. STATEMENT BY APPLICANT

- |  |  |
|--|--|
| <p>1.1 - And Nervous disorder including nerves, neurasthenia or anxiety state?    <input type="checkbox"/> YES    <input type="checkbox"/> NO</p> <p>1.2 - Headaches    <input type="checkbox"/> YES    <input type="checkbox"/> NO</p> <p>1.3 - Fits or convulsions, turns or blackouts, fainting or giddiness?    <input type="checkbox"/> YES    <input type="checkbox"/> NO</p> <p>1.4 - Head injury or concussion?    <input type="checkbox"/> YES    <input type="checkbox"/> NO</p> <p>1.5 - Tuberculosis or other lung trouble?    <input type="checkbox"/> YES    <input type="checkbox"/> NO</p> <p>1.6 - Rheumatic fever or heart disease?    <input type="checkbox"/> YES    <input type="checkbox"/> NO</p> <p>1.7 - Indigestions, gastric or duodenal ulcer?    <input type="checkbox"/> YES    <input type="checkbox"/> NO</p> <p>1.8 - Kidney or bladder trouble?    <input type="checkbox"/> YES    <input type="checkbox"/> NO</p> | <p>1.9 - Diabetes?    <input type="checkbox"/> YES    <input type="checkbox"/> NO</p> <p>1.10 - Anemia or any other blood disease?    <input type="checkbox"/> YES    <input type="checkbox"/> NO</p> <p>1.11 - Deafness or noise in the ear?    <input type="checkbox"/> YES    <input type="checkbox"/> NO</p> <p>1.12 - Earache or discharge from the ear?    <input type="checkbox"/> YES    <input type="checkbox"/> NO</p> <p>1.13 - Chronic sinusitis?    <input type="checkbox"/> YES    <input type="checkbox"/> NO</p> <p>1.14 - Any surgical operations?    <input type="checkbox"/> YES    <input type="checkbox"/> NO</p> <p>1.15 - Any injury?    <input type="checkbox"/> YES    <input type="checkbox"/> NO</p> <p>1.16 - Any illness not already mentioned    <input type="checkbox"/> YES    <input type="checkbox"/> NO</p> <p>1.17 - Are you taking any injections, tablets or other forms of medication?    <input type="checkbox"/> YES    <input type="checkbox"/> NO</p> |
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If **YES** to any of the above questions, give full details here:

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### APPLICANT'S DECLARATION (An applicant making a false declaration is liable to refusal or cancellation of licence)

I hereby declare that I have carefully considered the statements made above, and that, to the best of my belief, they are complete and correct, and that I have not withheld any relevant information or made any misleading statement. Furthermore I declare that, should any of the above conditions become evident during the currency of this licence (including any on track incident requiring hospitalisation), I agree to abstain from exercising the privileges of this licence, and to notify the ANDRA Medical Assessor and submit myself for further medical examination, the results of which will be forwarded to him or her.

I hereby give my full authority the ANDRA Medical Assessor to obtain information from relevant Clinical Records, X-Ray and Pathology Reports from any Medical Officer I have previously attended. **NB: (Female Applicants Only):** I agree to abstain from exercising the privileges of this Licence while in the last four months of Pregnancy. **A fee of \$5.50 (inc GST) will be charged in the event that any additional correspondence is required occasioned by incomplete or incorrect applications.**

**SIGNATURE OF APPLICANT  
(OR GUARDIAN/ REPRESENTATIVE IF APPLICANT  
IS A MINOR)**

**SIGNATURE OF MEDICAL EXAMINER  
AS WITNESS**

**DATE**

**NAME/ADDRESS OF GUARDIAN OR REPRESENTATIVE WHERE  
APPLICABLE (PLEASE PRINT)**

#### OFFICE USE ONLY

- |                |                              |                             |
|----------------|------------------------------|-----------------------------|
| Glasses        | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Contact Lenses | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

ANDRA Assessors Signature

**NOTES FOR EXAMINERS**

**VISION TESTS**

- 12.2 Squint – vertical or horizontal obvious or become obvious when either eye is covered.
- 12.3 Eye fixed on examiner. Peripheral vision to hand movements – either eye separately.
- 12.4 Use Snellen's type at 6 metres  
EG: A - 6/6 eye readings  
D = 6 line at 6 metres OR D = 3 line at 3 metres  
A - 6/9 eye readings  
D = 9 line at 6 metres OR D = 4.5 line at 3 metres

**CONTACT LENSES**

If this examination is the applicant's 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 motor racing activities.

**BLOOD PRESSURE**

Blood pressure reading must be recorded in systolic/diastolic format

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

**MEDICAL REPORT - CONFIDENTIAL**

1. Patient Name

2. D.O.B  3. Height  4. Weight

5. Any deformity or limitation of movement

**6. CVS**

- 6.1 - Pulse Rate
- 6.2 - Rhythm
- 6.3 - Blood Pressure e.g. 120/70
- 6.4 - Any hypotension or other CVS drugs In use?  YES  NO
- 6.5 - Any CVS abnormality?  YES  NO

**7. RESPIRATORY SYSTEM**

- 7.1 - Any antihistamine or other respiratory Drugs in use?  YES  NO
- 7.2 - Any abnormality?  YES  NO

**8. URINE**

- 8.1 - Albumen  YES  NO
- 8.2 - Sugar  YES  NO

**9. ABDOMEN**

- Any abnormality  YES  NO

**10. CNS**

- 10.1 - Sedative or tranquiliser drugs?  YES  NO
- 10.2 - Any abnormality?  YES  NO

**11. ENT**

- 11.1 - Vestibular System?  YES  NO
- 11.2 - Any abnormality?  YES  NO

**12 VISION**

- 12.1 - Eyes – any abnormalities?  YES  NO
- 12.2 - Eye movements – cover test  YES  NO
- 12.3 - Fields – Confrontational test  YES  NO

**12.4 - Visual Acuity**

**NATURAL SIGHT**

RIGHT	LEFT
6/	6/

**WITH CORRECTION**

- Spectacles  YES  NO
- Contact Lenses  YES  NO

RIGHT	LEFT
6/	6/

**EXAMINERS COMMENTS**

On History

On Examination

Is there anything unfavorable in the applicants personality revealed by history, appearance or behaviour?

**STATEMENT BY MEDICAL EXAMINER (response required for all 3 questions below and boxes ticked)**

- In my opinion the applicant is fit to take part in motor racing activities  YES  NO
- I have witnessed and signed the applicant's statement on page one of this form.  YES  NO
- I have personally examined this applicant on this day

Signed

Date

**Medical Examiner's Name & Address (Block letters or stamp)**

Please forward completed form to:  
**The Medical Assessor ANDRA Head Office**  
11 McInnes Street Ridleyton SA 5008  
Fax: 08 8271 6988 or Email [info@andra.com.au](mailto:info@andra.com.au)