Southern California Speedboat Club
Racing Medical Examination

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Medical History

Have you ever had any of the following? For each "yes" checked describe condition in remarks.

Y	N	Condition	Y	N	Condition
		Frequent or severe headaches			Nervous trouble of any sort
		Dizziness or fainting spells			Any drug or narcotic habit
		Unconsciousness for any reason			Excess drinking habit
		Eye trouble except glasses			Attempted suicide
		Hay fever			Motion sickness requiring drugs
		Asthma			Military medical discharge
		Heart Trouble			Medical rejection from service
		High or low blood pressure			Admission to hospital
		Stomach trouble			Rejection for life insurance
		Kidney stone or blood in urine			Record of traffic convictions
		Sugar or albumin in urine			Record of other convictions
		Epilepsy or fits			Other illnesses

Remarks: _____

_____

_____

Medical Treatment in the Last Five Years

Date	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 issuance of SCSC any racing licensing to me.

Southern California Speedboat Club
Racing Medical Examination

Report of Medical Examination to be Completed by Physician

Normal	Abnormal	Attribute
		Head, face, neck and scalp
		Nose
		Sinuses
		Mouth and throat
		Ears, general (internal and external canals)
		Ear Drums (perforation)
		Eyes, general
		Ophthalmoscopic
		Pupils (equality and reaction)
		Ocular Mobility (associated with parallel movement, mystaginus)
		Lungs and chest (including breasts)
		Heart (thrust, size, rhythm, sounds)
		Vascular
		Abdomen and viscera (including hernia)
		Anus and rectum (hemorrhoids, fistula. rostrate)
		Endocrine system
		G-U system
		Upper and Lower extremities (strength, range of motion)
		Spine and other musculoskeletal
		Identify body marks, scars, tattoos
		Skin and lymphatic
		Neuralgic (tendon reflexes, equilibrium, senses, coordination
		Psychiatric (specify any personality deviation
		General systemic

Remarks (please describe each abnormality in detail) _____

_____

_____

_____

**** Note Medical procedures marked optional are recommended but not required for this medical examination****

HEARING	RIGHT EAR				LEFT EAR				DISTANT VISION		NEAR VISION
Whispered voice Standing sideways Distant ear closed	FT				FT				Right eye	20/	20/
	50	1000	2000	4000	50	1000	2000	4000	Left eye	20/	20/
Audiometer **(optional)** (decibel loss)									Both eyes	20/	20/

INTRAOCULAR TENSION (Optional)			
		Right Eye	Left Eye
	Tactile		
	Tonometric		

COLOR VISION (test used, number of plates missed)

FIELD OF VISION (Optional)	
Right Eye	Left Eye

HETEROPHORIA DIOPTERS (Optional)				
Distance	Escophoria	Exophoria	Right H.	Left H

BLOOD PRESSURE		
Recumbent MM Mercury	Systolic	Diastolic

PUISE (WRIST)		
Resting	After Exercise **(optional)**	2minutes after exercise **(optional)**

URINALYSI.		
Albumen	Sugar	ECG(Date) **(optional)**

OTHER TESTS

COMMENTS ON HISTORY AND FINDINGS

APPLICANTS NAME:	DISQUALIFYING DEFECTS:

	PASSED
	NOT PASSED, FURTHER EVALUATION REQUIRED
	Has been denied, letter of denial issued (Copy Attached)

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.

EXAM1NATI0N DATE	MEDICAL EXAMINER'S NAME AND ADDRESS	MEDICAL EXAMINER'S SIGNATURE