AMERICAN POWER BOAT ASSOCIATION

(Reminder-Keep this form to present at races or upload to your APBA/Trackside profile)

INBOARD MEDICAL FORM

NAME: _____ APBA #: _____ DATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ EMAIL: _____

EMERGENCY CONTACT: _____ PHONE: _____

Applicant: complete page 1 as applicable and sign; Physician/Practitioner: complete page 2, sign, and return to applicant. Applicant: when complete, make copy for reference, send original to APBA office.

ALLERGIES: _____

MEDICINES (current): _____

HOSPITALIZATIONS/SURGERIES: _____

SPECIAL CONDITIONS: check if applicable, add appropriate information

Corrective lenses: [ ] _____
Blood Pressure: [ ] _____
Heart trouble: [ ] _____
Fainting / Dizziness: [ ] _____
Headaches: [ ] _____
Diabetic: [ ] _____
Asthma: [ ] _____
Insect Sting: [ ] _____
Other (describe): [ ] _____

APPLICANT SIGNATURE: _____ DATE: _____

APPLICANT'S DECLARATION: I hereby certify all statements and answers provided by me in this examination form are true to the best of my knowledge, and I agree that they are considered part of the basis for issuance of any APBA certificate to me. By submitting this information I agree the information is provided to the association for the specific purposes of determining basic physical fitness. The association will take usual and customary measures to protect the privacy and security of this information and disclose it only as needed to support the administration of racing.

PHYSICAL EXAM

Physician/Practitioner: please fill out page 2 as applicable, sign and date, return to applicant.

Blood Pressure: _____/_____ Comment: _____

Temperature: _____ Comment: _____

Heart: _____ Comment: _____

Breathing: _____ Comment: _____

Ear:

Canals: _____ Comment: _____

Drum perforation: _____ Comment: _____

Vision:

Corrective lenses: _____ Comment: _____

Pupil equality / reaction: ___Comment: _____

Ocular mobility: _____Comment: _____

Extremities

Range of motion: _____ Comment: _____

Reflex: _____ Comment: _____

General: _____ Comment: _____

_____

_____

_____

_____

Physician/Practitioner Signature: _____ Date: _____

Physician/Practitioner name / title (print): _____

PHYSICIAN/PRACTICTIONER'S DECLARATION: I hereby certify all statements and answers provided by me in this examination form are true to the best of my knowledge, and I agree that they are considered part of the basis for issuance of any APBA racing license to the above-listed participant. By signing, I agree that this person is physically capable of participating in the APBA.