The Australian Formula Jet Sprint Association

MEDICAL EXAMINATION FORM

PLEASE COMPLETE SECTIONS 1,2 (2B if applicable) AND 3 BEFORE ATTENDING A MEDICAL EXAMINATION

DOCTOR'S NAME/STAMP/DATE

SECTION 1: DRIVER DETAILS

SURNAME: **FIRST NAME:**

ADDRESS:

CITY: **POSTCODE:**

HOME PHONE: **DOB:** / /

WORK PHONE: **AGE:**

MOBILE: **SEX:** M ☐ F ☐

SECTION 2: PREVIOUS MEDICAL HISTORY *(Please indicate yes or no as relevant to the following questions)*

1	Nervous disorder (eg. nerves, anxiety attacks)?	Yes ☐	No ☐	12	Injuries related to motorsport?	Yes ☐	No ☐
2	Headaches?	Yes ☐	No ☐	13	Other injuries?	Yes ☐	No ☐
3	Fits, convulsions, blackouts, fainting, giddiness?	Yes ☐	No ☐	14	Other illnesses not mentioned?	Yes ☐	No ☐
4	Asthma, lung disease, respiratory problems?	Yes ☐	No ☐	15	Do you suffer any bleeding disorder?	Yes ☐	No ☐
5	Epilepsy?	Yes ☐	No ☐	16	Do you take any medication on a regular basis?	Yes ☐	No ☐
6	Head injury or concussion?	Yes ☐	No ☐	17	Do you suffer any known allergies?	Yes ☐	No ☐
7	Diabetes?	Yes ☐	No ☐	18	Have you ever been denied life insurance?	Yes ☐	No ☐
8	Heart disease?	Yes ☐	No ☐	19	Do you suffer partial/full eye blindness?	Yes ☐	No ☐
9	Deafness or noises in the ear (eg. ringing etc)?	Yes ☐	No ☐		UIM ANTI-DOPING FORMS COMPLETED BY APPLICANT (AND DOCTOR AS NECESSARY)		
10	Ear-ache or discharge?	Yes ☐	No ☐	20	UIM Acknowledgment and Agreement Form?	Yes ☐	No ☐
11	Surgical operation?	Yes ☐	No ☐	21	UIM Therapeutic Use Exemption Form (if applicable)?	Yes ☐	No ☐

IF YOU ANSWERED 'YES' TO ANY QUESTION 1-19 ABOVE, PLEASE STATE QUESTION NUMBER AND GIVE FULL DETAILS HERE. YOUR DOCTOR WILL BE EXPECTED TO COMMENT ON THESE IF NECESSARY. CONTINUE ON TO SECTION 2B IF INSUFFICENT SPACE.

Please tick here if you continued onto Section 2B Y ☐

SECTION 3: DECLARATION *(Note: An applicant making a false declaration is liable to refusal or cancellation of license)*

I hereby declare that I do not suffer from any serious illness, disease or restricted vision and that to the best of my belief I have not withheld any relevant information.

Furthermore I declare that should I at anytime while holding an Australian Formula Jet Sprint Association competition license, suffer from any illness, disease, or any disability of any kind whether permanent or temporary which is likely to detrimentally affect my control, ability, fitness to compete then I agree to abstain from using the privileges of this license and to notify the Australian Formula Jet Sprint Association and submit myself for further medical examinations, the result of which will be forwarded to the Australian Formula Jet Sprint Association.

For female applicants: I agree to abstain from exercising the privileges of this License while in the last six (6) months of pregnancy.

PRINT INITIALS AND SURNAME OF APPLICANT:

SIGNATURE OF APPLICANT:

I consent to the information above, in accordance with the Privacy Act 1993

WITNESS (Print initials and Surname):

SIGNATURE OF WITNESS:

SECTION 4: MEDICAL PRACTITIONERS DECLARATION *(Only to be completed if applicant is fit to race)*

This is to certify that I have examined the above named person clinically, including eyes, heart, lungs and blood pressure.

I have conducted a vision and colours blindness test and he/she is positively able to identify the colours of flags etc used by the Australian Formula Jet Sprint Association members, eg. Red, Green, Black, White, Yellow and Black and White chequered.

This examination does not reveal anything that would make it unsafe for him/her to compete in Australian Formula Jet Sprint Association sanctioned events:

SIGNATURE OF DOCTOR:

DATE OF EXAMINATION:

DOCTOR'S NAME/STAMP/DATE

afjsa
The Australian Formula Jet Sprint Association

MEDICAL EXAMINATION FORM

SECTIONS 4, 5, 6 (and 5B if applicable) TO BE COMPLETED AND CERTIFIED BY MEDICAL PRACTITIONER ONLY

DOCTOR'S NAME/STAMP/DATE

This applicant is being assessed for medical fitness to partake in high speed motor boat racing.

1. Please attach any specialists reports, or any pathology, or radiology results relevant to this application.
2. The normal answer to each of the questions below is **NO**.
   In respect of each **YES** answer, further details/comments should be provided in **SECTION 6 - EXAMINERS COMMENTS.**
3. Please check **SECTION 2 (and 2B, page 3) ANY PREVIOUS MEDICAL HISTORY** and comment or investigate as necessary.
4. If any significant abnormalities are found, please obtain specialist opinion or pathology as indicated and return with this form.

SECTION 5: MEDICAL PRACTITIONER EXAMINATION *(Please record or tick the yes or no column as appropriate)*

CARDIOVASCULAR SYSTEM	
What is the pulse rate?	
Is the rhythm normal?	Y ☐ N ☐
Blood pressure reading?	/
Are peripheral pulses abnormal?	Y ☐ N ☐
Any evidence in the history or exam of past or present ischemic heart disease?	Y ☐ N ☐

RESPIRATORY SYSTEM	
Is there abnormality of the respiratory system on clinical examination?	Y ☐ N ☐

ABDOMEN	
Is there abnormality of the abdomen on clinical examination?	Y ☐ N ☐

ENT SYSTEM	
Is there abnormality of the ENT System on clinical examination?	Y ☐ N ☐
Any evidence of past/present vestibular disturbance, include intermittent conditions?	Y ☐ N ☐

LOCOMOTOR SYSTEM	
Has the applicant undergone amputation of any limb or part of a limb, or is there any physical deformity?	Y ☐ N ☐
Does the applicant wear any form of orthopedic device?	Y ☐ N ☐
Has the applicant impaired use or movement of any limb, joint, hand or foot which might impair or compromise control of a motorboat at speed?	Y ☐ N ☐

CENTRAL NERVOUS SYSTEM	
Is there any abnormality of the cranial nerves, limb tone, power or co-ordination or tendon or plantar response on exam?	Y ☐ N ☐
Is there any sensory impairment?	Y ☐ N ☐

VISUAL SYSTEM	
Has the applicant any deformity of the eyes?	Y ☐ N ☐
Is there evidence of horizontal or vertical squint?	Y ☐ N ☐
Is there any abnormality or defect in the visual field on confrontment?	Y ☐ N ☐

VISUAL ACUITY (Snellens)	For distance L	For distance R
Unaided	6 /	6 /
Spectacles	6 /	6 /
Contacts	6 /	6 /
Is the colour vision abnormal?	Y ☐ N ☐	
Was Ishihara method used?	Y ☐ N ☐	
If **NO** please specify method used:		

COMMENTS IN RELATION TO SECTION 2 (any previous medical history)

Please tick here if you continued onto Section 2B Y ☐

SECTION 6: MEDICAL PRACTITIONER EXAMINERS COMMENTS *(Please continue on to Section 6B if necessary)*

Notable problems/conditions:

Medications:

Disabilities:

Allergies:

Examiners comments:

Please tick here if you continued onto Section 6B (page 3) Y ☐

Are there any unfavourable traits in the applicants personality revealed by history, appearance or behaviour?

In your opinion is the applicant fit to participate in motor boat racing YES ☐ NO ☐ DOUBTFUL ☐

STATEMENT BY THE EXAMINER:
I have today personally examined this applicant:

Signature: Date:

DOCTOR'S NAME/STAMP/DATE

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THESE SECTIONS ARE SUPPLIED FOR EITHER THE APPLICANT OR DOCTOR TO ADD FURTHER COMMENTS AS REQUIRED

DOCTOR'S NAME/STAMP/DATE

Applicant, have you added any pages, documents etc? YES ☐ NO ☐ If yes, how many pages added? ☐

Doctor, have you added any pages, documents etc? YES ☐ NO ☐ If yes, how many pages added? ☐

SECTION 2B: PREVIOUS MEDICAL HISTORY continued *(If applicable)*

IF YOU ANSWERED YES TO ANY QUESTIONS IN SECTION 2, PLEASE STATE QUESTION NUMBER AND GIVE FULL DETAILS HERE.
YOUR DOCTOR WILL BE EXPECTED TO COMMENT ON THESE IF NECESSARY.

SECTION 5B: MEDICAL PRACTITIONER EXAMINATION continued *(If applicable)*

SECTION 6B: MEDICAL PRACTITIONER EXAMINERS COMMENTS continued *(If applicable)*

OFFICE USE ONLY

1 Date application received / /

2 Any adverse comments YES ☐ NO ☐

3 If yes, date passed on? / /

License # Issued: / /

Signed: **Position:**

Application decision process: (If required due to medical concerns)

Doctor contacted re concern: / / Committee discussed: / /

Meeting with applicant : / / Final decision made: / /

Application Accepted: ☐ **Declined:** ☐ Date applicant advised / /

Signed: **Position in Code:**