ATLANTIC REGION MOTOR SPORTS INC.

REPORT OF MEDICAL EXAMINATION FOR COMPETITION LICENSE

APPLICANT'S MEDICAL HISTORY

NAME:____ **AGE:**_________ **DATE OF BIRTH:**__________________ **SEX:**_______

ADDRESS:_____________________________________ **OCCUPATION:**_________________________ **[ ] Married: [ ] Single**

____

PERSONAL PHYSICIAN:

___________________________**ADDRESS:**____

EXAMINING PHYSICIAN:___________________________**ADDRESS:**

____

(A) Have you been treated for, have you ever had or have you now any of the following?

YES	FOR EACH "YES" CHECKED - DESCRIBE OR EXPLAIN BELOW OR ON A SEPARATE SHEET	NO
	1. Frequent or Severe Headaches	
	2. Dizziness or Fainting Spells	
	3. Unconsciousness for any Reason	
	4. Eye Trouble Except Glasses	
	5. Hearing Problems	
	6. Asthma or Hay Fever	
	7. Allergy to Medications or Other Drugs in Addition to Asthma and Hay Fever	
	8. Diabetes - Insulin and How Much	
	9. Heart Trouble	
	10. High of Low Blood Pressure	
	11. Anemia or Other Blood Diseases Including Abnormal Bleeding	
	12. Stomach Trouble	
	13. Kidney Stone or Blood in Urine	
	14. Sugar or Albumin in Urine	
	15. Epilepsy or Fits	
	16. Nervous Trouble of Any Sort	
	17. Any Mental Trouble	
	18. A Drug or Narcotic Habit	
	19. Excessive Drinking Habit	
	20. Attempted Suicide	
	21. Motion Sickness Requiring Drugs	
	22. Admission to Hospital	
	23. Operations Involving Eyes / Brain / Heart / Nerves / Blood Vessels	
	24. Amputation or Physical Disability	
	25. Other Illness	
	26. Immunization Against Tetanus (by toxoid) - **LIST DATE BELOW**	
	27. Tetanus Boosters - **LIST DATES BELOW**	
	28. Rejection for Life Insurance	
	29. Medical Rejection From or For Military Service	
	30. Medical Military Discharge	
	31. Disability Compensation from the Veterans Administration, Compensation Insurance Comp. or any Other Government Agency	
	32. Previous Waiver for Medical Defects from ASN Canada FIA / Sports Car Club of America, or Other Sport Body (**EXPLAIN**)	
	33. Corrective Eyeglasses or Contact Lenses	
	34. Partial or Complete Dentures	

REMARKS

(B) List any medications currently used. (Including Eye Drops)
(C) Have you had an automobile accident, including racing, in the past two (2) years? IF YES, explain or describe.

This is to certify that the above statements are true and accurate. I also give permission to any Hospital, Institution or Physician to furnish any information relative to my condition to Atlantic Region Motor Sports Inc.

APPLICANTS SIGNATURE:____ DATE:_________________

WITNESS' SIGNATURE: ____DATE:_________________
(Examining Physician)

Rev. Dec 99