

American Power Boat Association

17640 Nine Mile Road, Eastpointe, Mi 48021

Phone (586) 773-9700, Fax (586) 773-6490

Inboard Racing Medical Form Rev. 01/05

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 Within the Past Five Years

Date	Name of 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 any APBA certificate to me.*

Report of Medical Examination

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 parallel movement, nystagmus)
		Lungs and chest (including breasts)
		Heart (thrust, size, rhythm, sounds)
		Vascular system
		Abdomen and viscera (including hernia)
		Anus and rectum (hemorrhoids, fistula, prostrate)
		Endocrine system
		G-U system
		Upper and lower extremities (strength, range of motion)
		Spine and other musculoskeletal
		Identifying 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)						COLOR VISION (test used, number of plates missed)						
		Right Eye		Left Eye								
Tactile												
Tonometric												
FIELD OF VISION (optional)						HETEROPHORIA DIOPTERS (optional)						
Right Eye		Left Eye				Distance	Escophoria	Exophoria	Right H.	Left H.		
BLOOD PRESSURE						PULSE (Wrist)						
Recumbent MM Mercury	Systolic	Diastolic				Resting		After Exercise (optional)		2 minutes after exercise (optional)		
URINALYSIS		ECG (Date) (optional)		OTHER TESTS								
Albumen	Sugar											
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.												
EXAMINATION DATE		MEDICAL EXAMINER'S NAME AND ADDRESS				MEDICAL EXAMINER'S SIGNATURE						