Doctors Name / stamp / Date

# MEDICAL EXAMINATION FORM:

Please complete sections 1, 2, (2B If applicable) and 3 before attending medical examination

## SECTION 1: APPLICANT DETAILS

| | | | |
|---|---|---|---|
| **SURNAME:** | **FIRST NAME:** | **HOME:** ( ) | **DOB** / / |
| **ADDRESS:** | | **WORK:** ( ) | **AGE:** |
| **CITY:** | **POSTCODE:** | **MOB:** | **SEX:** M F |

## SECTION 2: ANY PREVIOUS MEDICAL HISTORY *Please indicate yes or no as relevant to the following questions.*

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1 | Nervous disorder (e.g. nerves, anxiety attack)? | Yes | | No | 11 | Surgical operation? | Yes | No |
| 2 | Headaches? | Yes | | No | 12 | Injuries related to Motor Sport | Yes | No |
| 3 | Fits, convulsions, blackouts, fainting, giddiness | Yes | | No | 13 | Other injuries? | Yes | No |
| 4 | Asthma, lung disease, respiratory problems? | Yes | | No | 14 | Other illnesses not mentioned? | Yes | No |
| 5 | Epilepsy? | Yes | | No | 15 | Do you suffer any bleeding disorder? | Yes | No |
| 6 | Head injury or concussion? | Yes | | No | 16 | Do you take any medication on a regular basis? | Yes | No |
| 7 | Diabetes? | Yes | | No | 17 | Do you suffer any known allergies? | Yes | No |
| 8 | Heart disease | Yes | | No | 18 | Have you ever been denied life insurance? | Yes | No |
| 9 | Deafness or noises in the ear (e.g. ringing etc)? | Yes | | No | 19 | Suffer partial / full single eye blindness | Yes | No |
| 10 | Earache or discharge? | Yes | | No | 20 | | Yes | No |

*IF YOU ANSWERED YES TO ANY QUESTION ABOVE PLEASE STATE QUESTION NUMBER AND GIVE FULL DETAILS HERE. YOUR DR WILL BE EXPECTED TO COMMENT ON THESE IF NECESSARY. CONTINUE ON SECTION 2B (Page 3) IF INSUFFICIENT SPACE.*

***Please tick here if you have continued onto section 2B (Page 3):*** 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 a New Zealand Power Boat Federation Inc. 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 New Zealand Power Boat Federation and submit myself for further medical examinations, the result of which will be forwarded to the New Zealand Power Boat Federation.

**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 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 NZPBF members, e.g. 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 New Zealand Power Boat Federation sanctioned events:

**SIGNATURE OF DOCTOR:** _____

**DATE OF EXAMINATION:** _____

Doctors stamp:

Doctors Name / stamp / Date

# MEDICAL EXAMINATION FORM:

Sections 4, 5, 6 (and 5B, 6B if applicable) to be completed and certified by Medical Practitioner only

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

1 Please attach any specialist 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.
5 Please check **Section 2 (and 2B, Page 3) ANY PREVIOUS MEDICAL HISTORY** and comment or investigate as necessary.

## 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 any abnormality of the respiratory system on clinical examination? | Y | N |

| ABDOMEN | | |
|---|---|---|
| Is there any abnormality of the abdomen on clinical examination? | Y | N |

| ENT SYSTEM | | |
|---|---|---|
| Is there any 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 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 have continued onto section 5B (Page 3):*** | Y |

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

**Notable problems / conditions**

Medications: _____

Disabilities: _____

Allergies:

**Examiners comments:**

***Please tick here if you have continued onto section 6B (Page 3):*** Y

**Are there any unfavorable traits in the applicants personality revealed by history, appearance or behavior?**

**In your opinion is the applicant fit to participate in motor boat racing** **Yes** **No** **Doubtful**

**STATEMENT BY EXAMINER:**

I have today personally examined this applicant: _____ _____

Signature: Date:

Doctors Name / stamp / Date

Doctors Name / stamp / Date

# MEDICAL EXAMINATION FORM:

These sections are supplied for either the applicant or Dr to add further comments as required

**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: ANY PREVIOUS MEDICAL HISTORY CONTINUED: *(If Applicable)*

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

## SECTION 5B: MEDICAL PRACTITIONER EXAMINATION COMMENTS 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)*

Dr contacted re concern / / Committee discussed / /

Meeting with applicant / / Final decision made / /

Application Accepted: Declined: Date applicant advised / /

Signed Position in Code