MEDICAL EXAMINATION RECORD

ANDRA, 287 Payneham Road, Royston Park, SA 5070
E: info@andra.com.au SMS: 0437 933 745

New licence holder: ☐ Renewal: ANDRA licence Number

Surname		Given Names	
Postal Address			
Suburb		State/ Postcode	
Email			
Phone: Business		Phone: Mobile	
Birth Date		Gender	
Occupation			
Licence Type		Vehicle Type	

HEALTH STATEMENT *(must be completed by all applicants)*

PLEASE TICK IF YOU HAVE ANY SIGNIFICANT OR RECURRENT PROBLEMS WITH THE FOLLOWING:

Anxiety/Depression or other Mental Health Condition	☐	Headaches/ Migraine/ Head Injury	☐
Fits/ Fainting/ Dizziness	☐	Diabetes	☐
Epilepsy	☐	Heart Disease	☐
Asthma or significant lung trouble	☐	Allergies	☐
Anemia or other blood disease	☐	Glasses or contact lenses while driving	☐
Hearing Loss or Deafness	☐	Any Illness not already mentioned	☐

If you have ticked any of the above, please provide additional information relating to your condition

Please list **ANY** prescribed medications ANDRA Therapeutic Use Form (if required)

APPLICANT DECLARATION *(An applicant making a false declaration is liable to refusal or cancellation of licence)*

I hereby declare that I have carefully considered the statements made above, and that, to the best of my belief, they are complete and correct, and that I have not withheld any relevant information or made any misleading statement. Furthermore I declare that, should any of the above conditions become evident during the currency of this licence (including any on track incident requiring hospitalisation), I agree to abstain from exercising the privileges of this licence, and to notify the ANDRA Medical Assessor and submit myself for further medical examination, the results of which will be forwarded to him or her.

I hereby give my full authority to the ANDRA Medical Assessor to obtain information from relevant Clinical Records, X-Ray and Pathology Reports from any Medical Officer I have previously attended. **NB: (Female Applicants Only):** I agree to abstain from exercising the privileges of this Licence while in the last four months of Pregnancy.

SIGNATURE OF APPLICANT (OR GUARDIAN/ REPRESENTATIVE IF APPLICANT IS A MINOR) **DATE**

NAME AND ADDRESS OF GUARDIAN/ REPRESENTATIVE WHERE APPLICABLE (PLEASE PRINT)

NOTES FOR EXAMINERS

VISION TESTS

Squint – vertical or horizontal obvious or become obvious when either eye is covered
Eye fixed on examiner. Peripheral vision to hand movements either eye separately.
Use Snellen's type at 6 metres EG: A - 6/6 eye readings D = 6 line at 6 metres OR D =3 line at 3 metres
A - 6/9 eye readings D = 9 line at 6 metres OR D = 4.5 line at 3 metres

CONTACT LENSES

If this examination is the applicant's first wearing of contact lenses a report from the ophthalmologist is required, stating their (1) stability; (2) duration of daily use and (3) suitability for motor racing activities.

BLOOD PRESSURE

Blood pressure reading must be recorded in systolic/diastolic format **- MAXIMUM READING 150/90 (both must be at or below)**

PLEASE ATTACH ANY SPECIALISTS' REPORTS, PATHOLOGY, OR RADIOLOGY RESULTS RELEVANT TO THIS REPORT.

MEDICAL REPORT - CONFIDENTIAL

Applicant's Name

D.O.B | Height (in cm) | Weight (in kg)

Any deformity or limitation of movement

CARDIOVASCULAR SYSTEM

Pulse Rate? (MAX 100)

Is the Rhythm abnormal? Yes ☐ No ☐

Blood Pressure? (MAX 150/90) /

Any abnormality of the cardiovascular system? Yes ☐ No ☐

RESPIRATORY SYSTEM

Any abnormality of the respiratory system? Yes ☐ No ☐

Is the patient a smoker? Yes ☐ No ☐

URINE

Does the applicant's urine contain

-Protein? Yes ☐ No ☐

-Glucose? Yes ☐ No ☐

-Other abnormality? Yes ☐ No ☐

CENTRAL NERVOUS SYSTEM

Is there any sensory impairment? Yes ☐ No ☐

Any sedative or tranquiliser drugs in use? Yes ☐ No ☐

ABDOMEN

Any abnormality on examination? Yes ☐ No ☐

ENT SYSTEM

Any evidence of past or present vestibular Disturbance, including intermittent conditions? Yes ☐ No ☐

Any abnormality of the ENT system? Yes ☐ No ☐

VISUAL SYSTEM

Any abnormality of the eyes on examination? Yes ☐ No ☐

VISUAL FIELDS

(CONFRONTATION TEST FOR EACH EYE SEPERATELY)

Any evidence of loss of visual fields in either eye? Yes ☐ No ☐

VISUAL ACUITY

Unaided (without contact lenses or glasses)

R	L
6 /	6 /

With contact lenses or glasses

Glasses Yes ☐ No ☐

Contact Lenses Yes ☐ No ☐

R	L
6 /	6 /

EXAMINER'S COMMENTS

On History

On Examination

Is there anything unfavorable in the applicant's personality revealed by history, appearance or behaviour?

STATEMENT BY MEDICAL EXAMINER

In my opinion the applicant is fit to take part in motor racing activities Yes ☐ No ☐ FURTHER ASSESSMENT ☐

Are you the applicant's normal GP? Yes ☐ No ☐

Medical Examiners Signature | Date

THIS MEDICAL REPORT IS VALID FOR 6 MONTHS FROM THE DATE OF EXAMINERS SIGNATURE

Medical Examiner's Name & Address (Block letters or stamp)

Please forward completed form to:
The Medical Assessor ANDRA Head Office
287 Payneham Road, Royston Park, SA 5070
Email info@andra.com.au or
SMS 0437 933 745 (SMS Only)