New Zealand Water Ski Racing Association Inc

Home of New Zealand Water Ski Racing

DRIVERS MEDICAL FORM

IMPORTANT NOTES TO APPLICANT

1. **Please complete sections 1 & 2 of this form. Print clearly with a black ballpoint pen. These sections must be done prior to visiting your Practitioner (Doctor).**
2. **Prior to your visit to your Practitioner you should telephone for an appointment.**
3. **Sections 1-4 of this form are retained by the Practitioner for their records.**
4. **Section 5 is to be returned to NZWSRA, PO Box 12561, Hamilton, 3248 or mailto: alice.mellow1@gmail.com**

SECTION 1 (to be completed by applicant)

SURNAME:_____

GIVEN NAMES: _____

RESIDENTIAL ADDRESS:_____

_____

CITY: _____ P/CODE_____

POSTAL ADDRESS (If different from residential address)_____

_____

CITY: _____ P/CODE_____

PHONE: (W) _____ (H)_____

Mobile: _____

OCCUPATION: _____

SECTION 2 (to be completed by applicant prior to appointment and presented to practitioner)

STATEMENT BY APPLICANT	Please tick	YES	NO
a) Do you, at present, have any disease or disability?			

Have you ever suffered from:

STATEMENT BY APPLICANT	Please tick	YES	NO
b) Anxiety State. Depression or any nervous or mental disorder			
c) Headaches- recurrent or severe?			
d) Epilepsy, fits, turns or blackouts?			
e) Fainting, giddiness or dizziness?			
f) Head injury or concussion?			
g) Tuberculosis, Bronchitis, Asthma or Pneumonia?			
h) Rheumatic Fever or Heart Disease?			
i) Indigestion, gastric or duodenal ulcer?			
j) Kidney or bladder trouble?			
k) Diabetes?			
l) Anaemia or other blood disorder?			
m) Jaundice, hepatitis or glandular fever?			
n) Noises in ear, earache or discharge?			
o) Chronic sinus trouble?			
p) Any surgical operation?			
q) Any fracture or broken bones?			
r) Any illness or injury not mentioned above?			
s) Do you wear glasses or contact lenses?			
t) Do you take any tablets, injections or other form of medication?			

For each 'Yes' answered, please provide full details (including dates where applicable) in space below:

_____

_____

Note: if there is not enough space here, please attach an additional page with details.

SECTION 3 (to be completed by applicant, witnessed by practitioner)

I,.....hereby declare that I have carefully considered my answers to the questions above, and that to the best of my knowledge that they are complete and correct and I have not withheld any information or made any misleading statement. Furthermore, I declare that, should I sustain any accident or injury, or should any of the above answers not continue to apply throughout the currency of any licence issued to me on the basis of this medical examination, I agree to immediately surrender such licence to the NZWSRA and agree to submit myself for a further medical examination. I authorise the Medical Assessor, or his/her representative of NZWSRA to obtain relevant clinical records, X-rays and pathology reports from any hospital or medical practitioner that I have previously attended. If a female applicant, I agree to abstain from exercising the privileges of this licence in the last four (4) months of pregnancy.

Date: _____ Signature of Applicant: _____

Signature of Practitioner: _____

SECTION 4 (to be completed by practitioner)

Report by Practitioner

AGE	HEIGHT	WEIGHT

PULSE RATE	BLOOD PRESSURE

	Tick Answers	
Cardiovascular System	**Normal**	**Abnormal**
Heart Size		
Heart Sounds		
Murmurs		
ECG (if required)		
Respiratory System	**Normal**	**Abnormal**
Air Entry		
Breath Sounds		
Abdomen	**Normal**	**Abnormal**
Viscera		
Hernia orifices		
ENT & Vestibular Systems	**Normal**	**Abnormal**
Ears – any abnormality		

	Tick Answers	
Central Nervous System	**Normal**	**Abnormal**
Intellect		
Deep reflexes		
Co-ordination		
Romberg test		
Limbs	**Normal**	**Abnormal**
Deformity		
Range of joint movement		
Urine	**Normal**	**Abnormal**
Protein		
Glucose		
Visual System	**Normal**	**Abnormal**
Eyes- any abnormality		
General inspection		
Eye movements, cover test		
Fields, confrontation test		

Visual Activity

Natural Sight	Right	Left
	6/	6/
With Correction Spectacles/ Contact Lenses	**Right**	**Left**
	6/	6/

SECTION 4- Cont. (to be completed by practitioner)

Practitioner Comments

On history:
On examination:

New Zealand Water Ski Racing Association Inc

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SECTION 5 (to be completed by practitioner)

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MEDICAL EXAMINATION RECORD

PLEASE PRINT CLEARLY WITH A BLACK BALL POINT PEN

APPLICANT DETAILS
Surname:
Given Name(s):
Address:
Date of Birth:

To be completed by practitioner

THIS FORM WILL NOT BE VALID UNLESS A MEDICAL PRACTITIONERS OFFICIAL STAMP EXISTS BELOW

This is to certify that I have examined, (applicants full name) _____

_____ clinically including eyes, heart, lungs and blood pressure.

- I have conducted a vision and colour blindness test and he/she is positively able to identify the colours of flags etc. used by your association.
- He/ she is fit with / without (delete one) corrective lenses to drive a race boat in competition.

This examination does not reveal anything that would make it unsafe for him/her to compete in any New Zealand Water Ski Racing Association event.

Practitioners Stamp

Practitioners Signature: _____

Date: _____