



YOUR MOTORSPORTS JOURNEY BEGINS HERE  
WWW.MCSCC.ORG

# MEDICAL FORM 2026

- Ages 14 – 39 – Medical valid for 5 years
- Ages 40 – 49 – Medical valid for 3 years
- Ages 50 – 69 – Medical valid for 2 years
- Ages 70+ - -- Medical valid for 1 year

**MEDICAL HISTORY:** Have you ever had, been treated for, or now have any of the following?

Fainting Spells      Epilepsy/seizures      Asthma      Head injury      Heart Trouble      Heat Stroke  
 Loss of consciousness      High blood pressure      Diabetes      Kidney Disease      Chest Pain      Take Insulin

IF YES, EXPLAIN \_\_\_\_\_

Do you take any medications, either prescription or over the counter?      YES      NO

IF YES, EXPLAIN \_\_\_\_\_

Do you have any allergies?      YES      NO

IF YES, EXPLAIN \_\_\_\_\_

Any operations/hospitalizations in the last 12 months?      YES      NO

IF YES, EXPLAIN \_\_\_\_\_

**THE FOLLOWING TO BE COMPLETED AND SIGNED BY AN MD, DO, PA-C, or NP**

Attention Examiner: While performing this exam, please keep in mind that racing cars is very stressful, both mental and physical. The driver can be in a confined space, experience an elevated heart rate and be exposed to temperatures approaching 140 degrees Fahrenheit while wearing multi-layer flame retardant clothing.

Blood Pressure _____	V	Uncorrected	Corrected	Field of Vision
	I	Right	20/_____	
Resting pulse _____	S	Left	20/_____	Right _____
	I			
With exercise _____	O	Both	20/_____	Left _____
	N			
2 min later _____				

Do you recommend the driver wear corrective lenses when driving?      YES      NO

Neurological (reflexes, motor, equilibrium, coordination) \_\_\_\_\_

Heart \_\_\_\_\_ Abdomen \_\_\_\_\_

Lungs \_\_\_\_\_ Hernia \_\_\_\_\_

Urine Sp. Gr \_\_\_\_\_ Alb \_\_\_\_\_ Sugar \_\_\_\_\_  
(To be done if hypertension, diabetes or renal disease is present).

(Physician's option:      Electrocardiogram results      NORMAL      ABNORMAL)

Explain \_\_\_\_\_

**Remove below this line and submit to the Licensing Director, NOT VALID IF NOT COMPLETED IN FULL**

Drivers Name: \_\_\_\_\_ MC License Type: \_\_\_\_\_

Address: \_\_\_\_\_ MC License #: \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Date of Birth: \_\_\_\_\_ (mm/dd/year)

**THE PORTION BELOW IS REQUIRED TO BE FILLED OUT IN FULL BY MEDICAL EXAMINER**

Examiner: by signing this it is your opinion that the above applicant **IS** physically fit to drive an automobile at high speeds.

Print Examiner Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Examiner Signature \_\_\_\_\_ **2026**