

**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** |
| 1. Do you, at present, have any disease or disability? |  |  |

Have you ever suffered from:

|  |  |  |
| --- | --- | --- |
| **STATEMENT BY APPLICANT Please tick** | **YES** | **NO** |
| 1. Anxiety State. Depression or any nervous or mental disorder |  |  |
| 1. Headaches- recurrent or severe? |  |  |
| 1. Epilepsy, fits, turns or blackouts? |  |  |
| 1. Fainting, giddiness or dizziness? |  |  |
| 1. Head injury or concussion? |  |  |
| 1. Tuberculosis, Bronchitis, Asthma or Pneumonia? |  |  |
| 1. Rheumatic Fever or Heart Disease? |  |  |
| 1. Indigestion, gastric or duodenal ulcer? |  |  |
| 1. Kidney or bladder trouble? |  |  |
| 1. Diabetes? |  |  |
| 1. Anaemia or other blood disorder? |  |  |
| 1. Jaundice, hepatitis or glandular fever? |  |  |
| 1. Noises in ear, earache or discharge? |  |  |
| 1. Chronic sinus trouble? |  |  |
| 1. Any surgical operation? |  |  |
| 1. Any fracture or broken bones? |  |  |
| 1. Any illness or injury not mentioned above? |  |  |
| 1. Do you wear glasses or contact lenses? |  |  |
| 1. 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:

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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** | |
| **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 |  |  |
| Colour vision test |  |  |

|  |  |  |
| --- | --- | --- |
|  | **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 |  |  |

**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: |
|  |



SECTION 5 (to be completed by practitioner)

**ONLY this page is required to be returned to NZWSRA**

**PO Box 12561, Hamilton, 3248 or mailto:** [**alice.mellow1@gmail.com**](mailto:al_ducky@ihug.co.nz)

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**