IMSA Medical Liaison Department
Toni Wright
Senior Medical Liaison Coordinator
Office: (386) 310-6434
Fax: (386) 310-6435
Ashlee Rice
IMSA Medical Administrative Assistant
Office: (386) 310-6438
Fax: (386) 310-6439

Dear Driver,

Please find enclosed the 2017 Driver History & Physical Examination, 2017 HIPAA Authorization for the Use and Disclosure of Health Information and ImPACT Testing Submission form.

Due to applicable laws in the various states in which you may compete, IMSA requires all drivers who are 18 and under at the time of his/her initial 2017 on-track participation to sign applicable forms for MINOR competitors. If you are 18 or under, please ensure the forms provided herein are labeled for Minor Drivers and are signed by your parent(s) or legal guardian. If you have not received the correct forms based upon your age, please contact the Medical Liaison Department for the appropriate documents.

It is vitally important for the safety and wellbeing of all competitors that the medical information you provide is accurate. Please thoroughly complete all sections of the History forms and sign and date in the designated location at the bottom of the form. Your personal physician should complete and sign the Physical Exam form based upon their review of your medical information and physical exam. Review and complete the top portion of the HIPAA Authorization form, initial lines A–G, and sign and date the bottom. Minors are required to have all of the above forms and the Consent for Treatment of a Minor form also signed by a parent or legal guardian in the spaces provided. Finally, if not already on file, you are required to submit documentation of an ImPACT test completed within the past two years. For any drivers not racing in any IMSA sanctioned races, submission of an ImPACT test is not required.

You are advised to schedule your physical examination in a timely manner and ensure that a licensed physician will be available to sign or co-sign your form (signatures of Physician Assistants or Nurse Practitioners will not be accepted). All forms must be received by the Medical Liaison Department prior to any 2017 on-track participation in any IMSA sanctioned events. Please retain a copy for your records and return all original forms to:

IMSA Medical Liaison Department
One Daytona Blvd.
Daytona Beach, FL 32114

Do not enclose these forms with any documents sent to other IMSA departments or representatives.

If you need assistance while completing your forms, please feel free to contact the Medical Liaison Department. Once these requirements have been fulfilled, your information will be applied across all IMSA-sanctioned series in which you may compete and you will not be required to duplicate this process for other IMSA series for the 2017 season. We thank you in advance for your cooperation.

Sincerely,

Medical Liaison Department
Enclosures

IMSA MEDICAL FORM REQUIREMENTS FOR AGE

	WeatherTech, Continental Tire, Prototype Lites, GT3 Cup U.S. and Canada, Lamborghini, Ferrari
Age 19 and Over	• Medical History form with driver signature • Physical signed by physician (M.D. or D.O.) • HIPAA Form, Initial A-G, signed at bottom • Valid ImPACT test dated within the last two years
Age 18 and Under	• Medical History form with driver & parental or legal guardian signatures • Physical signed by physician (M.D. or D.O.) • HIPAA Form, Initial A-G, with driver & parental or legal guardian signatures • Consent for Treatment of a Minor form (signed by parent or legal guardian) • Valid ImPACT test dated within the last two years

2017 IMSA Driver History and Physical

Submit Original Documents DIRECTLY to the Medical Liaison's Office

Pages 1 & 2 to be completed by the Driver and reviewed with Examining Physician

Page 3 to be completed by Examining Physician

Submission of this form with documented Physician's exam is required prior to any sanctioned on-track activity.

PLEASE PRINT CLEARLY

Legal Last Name	Legal First Name	Nick Name

Age	Date of Birth (Month/Day/Year)	Gender	Marital Status
		M F	S M

Home Address	City	State	Zip/Country
Mailing Address	**City**	**State**	**Zip/Country**

Home Phone	Cell Phone	Email

EMERGENCY CONTACTS (List two)

	Name	Relationship	Home Phone	Cell Phone
1				
2				

IMSA Series & Number of Race Vehicle

☐ WeatherTech Championship ☐ Continental Tire Challenge	☐ Prototype Lites Porsche GT3 Cup ☐ US ☐ Canada	☐ Ferrari Challenge ☐ Lamborghini Super Trofeo

Team Name	Entrant	Garage/Shop #
Name of PR Contact	**Email**	**Cell Phone**

Personal Primary Care Physician ☐ No Current Primary Care Physician

Name	Specialty

Address	City	State	Zip/Country

Office Phone	Office Fax

ALLERGIES

Medication Allergies ☐ NONE	Reactions might include symptoms such as: hives, rash and/or trouble breathing
Medication:	Reaction:
Medication:	Reaction:
Medication:	Reaction:
Medication:	Reaction:
Allergies to Insects, Food, Latex, Other ☐ NONE	**Reactions might include symptoms such as: hives, rash and/or trouble breathing**
Allergy:	Reaction:
Allergy:	Reaction:
Allergy:	Reaction:
Allergy:	Reaction:

MEDICATIONS

Including ALL prescription and routine Over the Counter Medications, Vitamins, Workout Supplements, Herbs, etc.

☐ NONE

Name of Medication	Dose	Frequency/Regimen	Date Started

2017 IMSA Driver History and Physical

Last Name: ______________________________ **First Name:** ______________________________

Have you **EVER** experienced any of the following? Please respond to **EACH** line item, place check mark next to the appropriate diagnosis or symptom if applicable and explain any **YES** response in the space below.

General		
☐ Anemia ☐ Blood Disease	**YES**	**NO**
Anesthesia Complications	**YES**	**NO**
Burns	**YES**	**NO**
Depression	**YES**	**NO**
☐ Difficulty Sleeping ☐ Sleep Apnea	**YES**	**NO**
High Cholesterol	**YES**	**NO**
Seasonal Allergies	**YES**	**NO**
☐ Skin Problem ☐ Psoriasis ☐ Eczema	**YES**	**NO**
Cardiac		
☐ Angina ☐ Chest Pain ☐ Coronary Artery Disease	**YES**	**NO**
High Blood Pressure	**YES**	**NO**
☐ Irregular Heartbeat ☐ Palpitations	**YES**	**NO**
Peripheral Vascular Disease (Circulatory Problem)	**YES**	**NO**
☐ Valve Disease ☐ Valve Replacement	**YES**	**NO**
Implanted Pacemaker	**YES**	**NO**
Automatic Implantable Cardioverter Defibrillator (AICD)	**YES**	**NO**
Pulmonary		
☐ Asthma ☐ Reactive Airway Disease	**YES**	**NO**
Bronchitis	**YES**	**NO**
Emphysema	**YES**	**NO**
Endocrine		
Diabetes	**YES**	**NO**
Thyroid disorder	**YES**	**NO**
Eyes, Ears, Nose, Throat		
Nose Bleeds	**YES**	**NO**
Throat Problem	**YES**	**NO**
☐ Hearing Deficit ☐ Hearing Loss	**YES**	**NO**
Do you use a hearing aid? ☐ **Right** ☐ **Left**	**YES**	**NO**
Vision Deficit or Loss	**YES**	**NO**
Corrective Eye Surgery (ex. Lasik, PRK) ☐ **Right** ☐ **Left**	**YES**	**NO**
Do you use contact lenses?	**YES**	**NO**
Do you use contact lenses while driving race vehicle?	**YES**	**NO**
Do you use corrective glasses?	**YES**	**NO**
Do you use corrective glasses while driving race vehicle?	**YES**	**NO**
Do you use corrective sunglasses?	**YES**	**NO**
Do you use corrective sunglasses while driving race vehicle?	**YES**	**NO**
Do you wear dentures?	**YES**	**NO**
Do you wear partial dental prosthesis?	**YES**	**NO**

Gastrointestinal		
Bowel Problem	**YES**	**NO**
Hernia	**YES**	**NO**
☐ Liver Disease ☐ Hepatitis ☐ Cirrhosis	**YES**	**NO**
☐ Stomach Ulcer ☐ Reflux	**YES**	**NO**
Neurological		
☐ ADD ☐ ADHD	**YES**	**NO**
☐ Concussion ☐ Head Injury	**YES**	**NO**
☐ Dizziness ☐ Vertigo ☐ Motion Sickness	**YES**	**NO**
☐ Fainting ☐ Syncope ☐ Loss of Consciousness	**YES**	**NO**
☐ Headaches ☐ Migraines	**YES**	**NO**
Memory Loss	**YES**	**NO**
☐ Seizures ☐ Epilepsy	**YES**	**NO**
☐ Stroke ☐ TIA	**YES**	**NO**
Orthopedic		
☐ Amputations ☐ Prosthesis (List sites below)	**YES**	**NO**
☐ Back ☐ Spine Problem	**YES**	**NO**
Broken Bones (Fractures)	**YES**	**NO**
Implanted Metal Plates, Pins or Screws (List sites below)	**YES**	**NO**
☐ Joint ☐ Muscle Problem	**YES**	**NO**
Neck Problem	**YES**	**NO**
Genitourinary		
☐ Kidney ☐ Bladder ☐ Urinary Problem	**YES**	**NO**
Prostate Problem	**YES**	**NO**
Social		
Tobacco use including smokeless tobacco	**YES**	**NO**
Alcohol use	**YES**	**NO**
Recreational drugs	**YES**	**NO**
Please explain any YES responses		
Any other injury, symptom or medical condition not otherwise listed:		
1.		
2.		
ImPACT/Neurocognitive Testing		
(Required for all – drivers racing in IMSA sanctioned events)		
Date of most recent test: ☐ **Baseline** ☐ **Post Injury**		

Hospitalizations (include **any/all** overnight hospital admissions) ☐ **NONE**

Date: _______/_______ Reason: ______________________________

Date: _______/_______ Reason: ______________________________

Date: _______/_______ Reason: ______________________________

Prior Surgical History ☐ **NONE**

Date: _______/_______ Reason: ______________________________

Date: _______/_______ Reason: ______________________________

Date: _______/_______ Reason: ______________________________

I certify that the information I have provided herein, or that I may provide to the International Motor Sports Association LLC ("IMSA") or its affiliates in the future, and any health care providers, is correct and complete. I further certify that I believe I am physically and psychologically fit to compete in motor vehicle racing in the 2017 IMSA season and I have no knowledge of any reason why I should not be allowed to compete. If at any time I do not personally believe that I am physically or psychologically fit to compete at any time for any reason, I will advise the IMSA Medical Liaison's Office in writing of my concern for my own fitness as soon as possible. I also certify that, should there be any change in my health status, information or medications that I will inform the Medical Liaison's Office of such change(s) as soon as practically possible, but in no event longer than five (5) business days of my discovery of such change(s).

DRIVER SIGNATURE: ______________________________ **Date:** ______________________

Revised August 2016

2017 IMSA Driver History and Physical

Last Name: ______________________________________ **First Name:** ___________________________________

PHYSICAL EXAM

Date of Exam: ____________________ Height: _____(ft)______(in) Weight: ______________(lbs) (*Actual weight on date of physical exam*)

Vital Signs

Temperature: _________(°F) Pulse: ____________ Rhythm: ____________ Respirations: ____________ Blood Pressure: ________/________

Most Recent Tetanus Immunization: ____________________ ☐ **UNKNOWN (if unknown, booster recommended)**

Snellen Visual Acuity		
	Without Corrective Lenses	**With Corrective Lenses/Glasses**
LEFT EYE (OS)	20 /	20 /
RIGHT EYE (OD)	20 /	20 /
Binocular (OU)	20 /	20 /

Body Systems		
	√ = Normal Exam	**Abnormal Findings**
General Appearance		
Head		
Eyes		
Ears		
Oropharynx		
Neck / Thyroid		
Chest		
Heart		
Lungs		
Back		
Spine		
Abdomen		
Pelvis		
Extremities		
Joints		
Peripheral Pulses		
Skin		
Mental Status		
Neurological		
Gait		

The undersigned Physician has reviewed the medical history and conducted a thorough physical examination on the patient identified above. As a result of that review and examination, the undersigned Physician finds no signs, symptoms or conditions that would preclude the patient from participating in motor vehicle racing. The patient is medically cleared to compete in all motor vehicle racing activities without restrictions.

Examining Physician Name (**please print clearly**): ____

Physician Signature: ____ Date: ______/_______/_______

*****Physician Assistant or Nurse Practitioner signatures must have Physician co-signature*****

******This form will not be accepted unless signed by a Physician******

Physician's License #: ___________________________ State/Country: _________ Expiration: ___________

Office Address: ____ City: ____________________ State: ________ Zip/Country: _________

Office Phone: (______) ________–____________ Office Fax: (______) ________–____________

HIPAA AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION
(DRIVERS / COMPETITORS)

Name:___________________________________ Telephone:(______)_______________ Date of Birth:__________________
Address:____

This Authorization Form describes different uses and disclosures of health information, including as protected under state law and also "protected health information" as defined by the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the regulations promulgated thereunder. Unless otherwise revoked by me in writing, this Authorization expires twelve (12) months after the date of signing this Authorization ("Expiration Date").

I hereby authorize the following uses and disclosures of my Health Information, as defined below, and as permitted or required by law:

_____ ***(initial)*** **A.** General. I specifically authorize and direct any physician, healthcare provider, hospital or other healthcare facility who provided or is providing assessment, diagnosis, care, treatment or services to me prior to execution of this Authorization and/or any time after execution of this Authorization up to the Expiration Date, including their agents, employees and medical staff (collectively "Health Care Provider") to release my "Health Information" (as defined below) to (1) the IMSA Medical Liaison Department and/or their designated agents and employees (collectively "Medical Liaison Department");and/or (2) NASCAR's Substance Abuse Policy's designated Medical Review Officer or its designated agent (collectively "Medical Review Officer") as requested by them for the purposes of safety, quality assurance/quality improvement, my ability or eligibility to compete, and/or my assessment, treatment or care, whether related to a medical, psychological, psychiatric, or substance abuse condition. *"Health Information" is defined as: the full and complete medical record; hospital chart; medical history; notes; reports; data; test results; radiology reports, images and films (such as CT, MRI, and x-ray); documents related to examination or treatment for any physical or mental health condition, sickness or injury; assessments; diagnoses; prognoses; medications and prescriptions; insurance records; physician notes of patient interviews; privileged or private communications; and any and all other health information or records regarding my health or treatment, including correspondence, patient notes, and phone messages. I understand Health Information includes records disclosed to the Health Care Providers by other healthcare providers and facilities who previously provided treatment to me, and that it may include information and records protected under state law (such as certain conditions) and federal law (such as alcohol or drug abuse).*

_____ ***(initial)*** **B.** Contagious, Infectious, or Communicable Disease. I specifically authorize and direct any Health Care Provider to release to the Medical Liaison Department to the Medical Review Officer any Health Information about me regarding assessment, diagnosis, care or treatment of a contagious, infectious or communicable disease (including, but not limited to, HIV/AIDS information, tuberculosis, measles, negative/positive diagnosis, testing, test results, status and treatment), if applicable.

_____ ***(initial)*** **C**. Mental Health Information. I specifically authorize and direct any Health Care Provider to release to the Medical Liaison Department to the Medical Review Officer any Health Information about me regarding assessment, diagnosis, care or treatment of a mental health condition, illness, or disease, if applicable, for the purposes of safety, quality assurance/quality improvement, my ability or eligibility to compete, and/or for my assessment, treatment or care. This Authorization does not include the release of "psychotherapy notes" (as that term is defined by HIPAA) recorded by a healthcare provider who is a mental health professional regarding a counseling session, but only if such notes are held separately from my medical record. This Authorization does include, for example, all information held in my medical record, other professional notes, medication prescriptions and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

_____ ***(initial)*** **D.** Alcohol/Drug Abuse. I specifically authorize and direct any Health Care Provider to release to the Medical Liaison Department and/or to the Medical Review Officer any Health Information about me regarding assessment, diagnosis, care, treatment or referral regarding alcohol and/or drug abuse, if applicable, for the purposes of safety, quality assurance/quality improvement, my ability or eligibility to compete, and/or for my assessment, treatment or care.

_____ ***(initial)*** **E.** Discussion Permitted. I specifically authorize and direct any Health Care Provider to discuss, clarify or explain my Health Information with the Medical Liaison Department and/or the Medical Review Officer, upon their request, for the purposes of safety, quality assurance/quality improvement, my ability or eligibility to compete, and/or for my assessment, treatment or care.

_____ ***(initial)*** **F.** Disclosure by Medical Liaison for Certain Purposes. I authorize the Medical Liaison Department to use and disclose my Health Information in their possession, including but not limited to my IMSA Driver History & Physical Forms, IMSA Incident Medical Reports, and Infield Care Center Reports, to the following: (1) physicians, health care providers, hospitals, infield care centers, and other health care facilities for purposes of my assessment, care and treatment; and/or (2) the Medical Review Officer, and outside experts, engineers, physicians or consultants retained by any of them, for purposes of safety, quality assurance/improvement, my ability or eligibility to compete, to assist in reviewing accidents and health care services, and making assessments and recommendations related to quality or safety. I understand the Medical Liaison Department coordinators and consulting physicians are not direct treatment providers; they are present at the racetracks to facilitate the sharing of information.

_____ ***(initial)*** **G.** Medical Review Officer Request. I acknowledge that, under the rules of IMSA's Substance Abuse Policy, the Medical Review Officer serves as an independent and impartial physician who investigates whether a laboratory non-negative test result was due to a legitimate medical explanation. I understand that under IMSA rules the Medical Review Officer may request medical information and records as part of inquiring into whether there is a legitimate medical explanation for a result. I specifically request and permit Health Care Providers and the Medical Liaison Department to disclose, discuss and explain my Health Information as necessary to respond to such a request from the Medical Review Officer.

I understand that I have the right to revoke this Authorization in writing at any time by notifying, as applicable, the disclosing Healthcare Provider, Medical Liaison Department, and/or the Medical Review Officer. I understand that the revocation is only effective after it is received. I understand that any use or disclosure made prior to the revocation in reliance on this Authorization will not be affected by a subsequently received revocation.

I understand that once Health Information is disclosed pursuant to this Authorization, it may be re-disclosed by the recipient, and federal or state law might not protect it. I understand a health care provider, hospital or health facility may not condition my treatment on whether this Authorization is signed. I understand that IMSA rules and policies will govern whether I may participate in any IMSA-sanctioned event if I choose to revoke this Authorization.

I have read this Authorization, I understand what it says, and any questions of mine have been answered to my satisfaction. I understand that I am entitled to receive a copy of this Authorization, and I allow a photocopy to be deemed valid as a signed original.

Signature:____ Date:________________________________

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Entrants & Drivers:

IMSA requires all drivers to complete a neurocognitive baseline ImPACT test prior to any IMSA-sanctioned on-track activity. The test must be performed within the last two years from date of membership application by a healthcare provider who is a credentialed ImPACT consultant. Please note, if your ImPACT Test expires in the middle of the season, you must complete a new test to continue racing.

Drivers may complete this requirement by going to https://www.impacttest.com/find_care_provider/ to find a provider near you.

The IMSA Medical Liaison Department will accept the ImPACT Test three different ways:

- The 5-page ImPACT Test report that you can obtain from your credentialed ImPACT consultant
- The ImPACT Test Submission form accurately completed by a credentialed ImPACT consultant
- The ImPACT Test Confirmation email that you will receive via the email address you use when you take the ImPACT Test

All medical forms including the ImPACT Test Submission form are available at http://competitors.imsa.com/credentials-membership-driver-application-forms or by contacting the IMSA Medical Liaison department.

The IMSA Medical Liaison department collects & retains all ImPACT test documents. After completing the test, a physiatrist (medical physician specializing in rehabilitation medicine) will review the test for validity & accuracy. Any concerns will be reported directly to the competitor.

For information and resources about concussions, visit The Center of Disease Control and Prevention website at http://www.cdc.gov/headsup/index.html.

The Medical Liaison Department is here to assist you. Please do not hesitate to contact us.

Sincerely,

Medical Liaison Department
Enclosures

ImPACT TEST SUBMISSION FORM

PLEASE TYPE OR PRINT

Driver Name: ____

Date of Birth: ________/_______/_______ Age: __________________

Cell Phone: ___________________

ImPACT Test Information

❐ I have attached the most recent ImPACT Test performed on _____ - _____ - 20_______

OR

❐ I have chosen not to provide a copy of my ImPACT Test. It was performed by:

____

Printed Name of Credentialed ImPACT Consultant Date

____

Signature of Credentialed ImPACT Consultant Date

Should a copy be necessary for evaluation and/or treatment, a copy will be on file and available within 24 hours per any request from a treating physician, at the following location:

____

Name

____

Address

_________________________ ________ ______________________

City State Zip

(____) _____________________ ______________________________

Phone Weekend Contact Information

Competitor Signature: ___________________________ Date: _______________

If you have any questions please contact the IMSA Medical Liaison Department.

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