MOTOR SPORTS SINGAPORE MEDICAL FORM 2017

ANNUAL MEDICAL EXAMINATION

Applicant's name: ____________________

Address: ____________________

Postal Code: __________ Nationality: __________ Date of Birth: __________

Medical Information

Vision	Right eye	Left eye
Uncorrected	6 /	6 /
Corrected	6 /	6 /

Height	(cm)
Weight	(kg)
Blood Pressure	/

Is there any evidence of abnormality of the heart or cardiovascular system?
If 'yes', give details below

Yes		No	

Is there any evidence of a physical or mental condition in the applicant's medical history?
If 'yes', give details below

Yes		No	

Has the applicant suffered from epilepsy, seizures or any other neurological conditions?
If 'yes', give details below

Yes		No	

Does the applicant have any physical abnormality or restriction of movement in the arms or legs? *If 'yes', give details below*

Yes		No	

If you have ticked "YES" to any of the questions above, please provide further details in the box below

Doctor's comments:

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Date	Doctor's Signature / Clinic Stamp	ASN Stamp