JOCKEY'S MEDICAL REPORT

Name of Applicant: .....

Date of birth .....

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1. Name and address of personal Doctor .....

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2. a) Has any relative – Father, mother, brother, sister, spouse, child, aunts, or uncles, ever suffered from: -

Asthma, Heart Disease, including High Blood pressure, Diabetes, Sickle Cell Disease, Epilepsy, Mental Disease, Tuberculosis or Cancer?

(Circle relative and disease)

b) Do you know or are aware of any other disease that runs in the family? yes no

If yes, give details.....

3. a) Have you ever suffered from or received treatment for:

(i) Frequent and recurring sore throat? yes no

(ii) Deafness or discharge from the ear? yes no

(iii) Problems with your eyes? yes no

b) Epileptic fits, frequent giddy or fainting spells, loss of consciousness or loss of use of a limb or disturbances of speech? .....

c) Recurrent or persistent cough, spitting of blood, pneumonia, asthma, tuberculosis, emphysema, shortness of breath? .....

d) Have you ever noticed skipping and irregularity of your heartbeat? yes no

Do you have pain or tightness or a feeling of weight in your chest on walking fast or climbing stairs or going up hills? yes no

Have you ever been told that you had high Bp, heart murmurs or any form of heart disease? yes no

e) Do you have Diabetes? yes no

Has any Doctor ever told you that you had glandular troubles such as Thyroid disease, or trouble with your ovaries or testicles? yes no

f) How many Alcoholic drinks do you have per day, per week? .....

How many cigarettes do you smoke daily? .....

Do you use Ganja (marijuana) or any hard drugs?.....

g) What medications are you now taking, and why? .....

.....

h) Has your weight changed in the past year? yes no

If so, why?.....

i) ***FEMALES ONLY:***

Are you now pregnant? yes no

Is so, how far advanced?.....

Name of Doctor/Clinic .....

4. Height

Weight

5. Blood Pressure

Systolic

4th phase

Diastolic

5th phase

6. ***Pulse***

	At rest	After exercise	3 mins. later
Rate			
Irregularities per min.			

7. Heart – is there any:

Murmur(s) yes no

(describe multiple murmurs separately)

Enlargement yes no

Dyspnea yes no

Edema yes no

8. Upon examination, is there any abnormality of the following:

a) Eyes, ears, nose, mouth, pharynx? .....

(If vision or hearing is markedly impaired, indicate degree and correction)

b) Skin (incl. scars): Lymph nodes; varicose veins or peripheral arteries?.....

.....

c) Nervous system (include reflexes, gain, paralysis?.....

.....

d) Respiratory system?.....

e) Abdomen (include scars)?.....

(If female, observe for signs of pregnancy and give details).

f) Endocrine system (include thyroid and breasts)? .....

.....

g) Musculoskeletal system (include spines, joints, amputations, deformities)?.....

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9. Are there any hernias?.....

Urinalysis

Specific Gravity Albumin Sugar Other

Please comment on any unfavourable features discovered either on examination or history, that you consider of importance to assessing the applicant's ability as a race rider.....

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MEDICAL OFFICER DECLARATION

In your clinical and professional judgement is this applicant a fit person to obtain a permit?.....

If "no", please attach a written report.

I certify that I have made a thorough physical examination of the applicant, and that the answers given are a true record of the examination.

Signed on the .....day of..... 20.....

Time.....a.m./p.m.

.....

Medical Examiner's signature

.....

Print Name

.....

Postal Address

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