



**MEDICAL SELF DECLARATION FORM**  
**Mandatory form to complete every year between  
each doctor performed medical exam**

In order to assess the risk that it may incur, Auto Sport Québec reserves the right to require a medical exam at all times.

The driver cannot participate in any competition unless he meets, and continues to meet, the medical requirements of the competition license described in Auto Sport Québec's sports regulations.

**SECTION 1. PERSONNAL INFORMATIONS:**

Name and first name: \_\_\_\_\_

Age: \_\_\_\_\_

Address – Number, street, apartment:  
\_\_\_\_\_

Date of birth (JJ/MM/AAAA) : \_\_\_\_\_

Occupation : \_\_\_\_\_

Town / Province: \_\_\_\_\_

Gender:     Male     Female

Postal Code: \_\_\_\_\_

**SECTION 2. VOLUNTARY MEDICAL DECLARATION:**

**Have you been treated for / were suffering from / do you currently suffer from one or more of the following symptoms?** (If you check yes to one or more of these items, please explain)

	YES	NO
Frequent or violent headaches	<input type="checkbox"/>	<input type="checkbox"/>
Loss of consciousness for any reason	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness or fainting	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems:		
Coronary or angina disease	<input type="checkbox"/>	<input type="checkbox"/>
Valvular disease	<input type="checkbox"/>	<input type="checkbox"/>
Left branch block	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal heart rhythms (arrythmia)	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure (HBP)	<input type="checkbox"/>	<input type="checkbox"/>
Mental or psychological health problems	<input type="checkbox"/>	<input type="checkbox"/>
Operation(s) affecting eyes, brain, heart, nerves, blood vessels, bones	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>
Eye troubles (except wearing glasses or contact lenses)	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Anemia or other blood diseases, including abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Hospitalization in the last 12 months	<input type="checkbox"/>	<input type="checkbox"/>
Amputations or physical incapacity	<input type="checkbox"/>	<input type="checkbox"/>
Drug use, narcotics or alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Previous medical withdrawal by ASQ or ASN Canada FIA	<input type="checkbox"/>	<input type="checkbox"/>
Previous medical exception granted by ASQ	<input type="checkbox"/>	<input type="checkbox"/>
Other illness not mentioned here:	<input type="checkbox"/>	<input type="checkbox"/>



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Name, first name: \_\_\_\_\_

**SECTION 2. VOLUNTARY MEDICAL DECLARATION (cont'd) :**

Blood type: \_\_\_\_\_

Date of your last recall for Tetanus: \_\_\_\_\_

Do you wear glasses or contact lenses:

YES  NO

Remarks: \_\_\_\_\_

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Any medical condition that could affect your ability to compete should be immediately reported to ASQ.

**SECTION 3 SIGNATURE :**

I, the undersigned, certify that the above statements are true and accurate. In addition, I give any hospital, institution or doctor permission to provide Auto Sport Québec with any information relating to my state of health.

Applicant's signature: \_\_\_\_\_

Date (jj-mm-aaaa): - -

Signature of the parent or guardian if the applicant is a minor: \_\_\_\_\_

Title:

Date (jj-mm-aaaa): - -