AMERICAN POWER BOAT ASSOCIATION

17640 NINE MILE ROAD, EASTPOINTE, MICHIGAN 48021

Ph: 586-773-9700, Fax: 586-773-6490

INBOARD MEDICAL FORM Rev. 5/2020

NAME: _______________________________ DATE:_________________________________

ADDRESS:____

CITY:____ STATE:____________ ZIP:________________

PHONE:___________________ EMAIL:____

EMERGENCY CONTACT: ____ PHONE: __________________

Applicant: complete page 1 as applicable and sign; Medical Examiner: complete page 2, sign, and return to applicant. Applicant: when complete, make copy for reference, send original to APBA office.

ALLERGIES:____

____

____

____

MEDICINES (current):____

____

____

____

____

HOSPITALIZATIONS/SURGURIES:____

____

____

____

____

SPECIAL CONDITIONS: check if applicable, add appropriate information

Corrective lenses: [ ]____

Blood Pressure: [ ]____

Heart trouble: [ ]____

Fainting / Dizziness: [ ]____

Headaches: [ ]____

Diabetic: [ ]____

Asthma: [ ]____

Insect Sting: [ ]____

Other (describe): [ ]____

____

____

APPLICANT SIGNATURE:____ DATE:_____________

APPLICANT'S DECLARATION: I hereby certify all statements and answers provided by me in this examination form are true to the best of my knowledge, and I agree that they are considered part of the basis for issuance of any APBA certificate to me.

PHYSICAL EXAM

Medical Examiner: please fill out page 2 as applicable, sign and date, return to applicant.

Blood Pressure: ______/_____ Comment: ____

Temperature: ____________ Comment: ____

Heart: __________________ Comment: ____

Breathing: _______________ Comment: ____

Ear:

Canals: ____________ Comment: ____

Drum perforation: ____ Comment: ____

Vision:

Corrective lenses: _______ Comment: ____

Pupil equality / reaction: __ Comment: ____

Ocular mobility: _________ Comment: ____

Extremities

Range of motion: ____ Comment: ____

Reflex: ____________ Comment: ____

General: _________________ Comment: ____

____

____

____

____

Medical Examiner Signature: ____ Date: _____________

Medical Examiner name / title (print): ____