

- 13. Fractures or Dislocations?
(Give site & order of any fractures and time off)
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-
- 14. Head injury, Concussion, Unconsciousness?
- 15. Skin Disease, Eczema or Dermatitis?
- 16. Any Surgical Operations?
- 17. Any Hospital Admissions?
(Reason for Admission if not already covered)
- 18. Any other Sickness or Injury?
- 19. Have you ever made a Claim on Workers' Compensation?
- 20. Do you at present take any Medicine, Drug, Tablet or injections?
- If yes, please name and specify dose and reason taken.
- 21. How many cigarettes do you smoke daily?
- 22. What is your daily consumption of alcohol?
- 23. Date of Tetanus Immunization?
To be within last 10 years.

CONSENT DECLARATION:

I hereby consent to the collection, use and disclosure by Thoroughbred Racing S.A. Limited of the information contained in this form for the purposes of any function considered necessary by TRSA Limited.

DECLARATION:

I declare that the information which I have set out in the Application is truthful and I understand that to make a false declaration is an offence under the Rules of Racing and might result in my licence (or registration) being refused or cancelled. I authorise the examining doctor to make this acquired information relating to my health available to the appropriate officials of Thoroughbred Racing S.A. Limited.

..... DATE:

SIGNATURE

..... DATE:

WITNESS

The area below should be used if space above is insufficient. Also please add any additional information concerning injury or illness after initial medical examination. Identify your remarks by the question number.

PRIVATE AND CONFIDENTIAL
THOROUGHBRED RACING S.A.
LIMITED
PHYSICAL EXAMINATION

SURNAME: GIVEN NAMES:

(Please Print) (Please Print)

Height : (Barefeet in cms)

Weight: (Underclothes) in kgs

EYES:

Any abnormality lids, conjunctivae Cornae?	Yes / No		Details
Visual acuity (Distant)	Right	Left	
Uncorrected	6/	6/	
Corrected	6/	6/	

EYE MOVEMENT:

Normal	Yes / No	
Fields (confrontation test)	Normal	Yes / No
Are contact lenses worn?		Yes / No

E.N.T.

Nose – abnormality		Yes / No	
Ears -	Right	Left	
Ext. Auditory canal:	Normal / Abnormal		Normal / Abnormal
Tympanic Membrane:	Normal / Abnormal		Normal / Abnormal
Conversational Voice at 2.5 metres binaural			Normal / Abnormal

MUSCULO SKELETAL SYSTEM:

- a) Spinal deformity or limitation of function. Yes / No
- b) Any abnormality in strength, range of movement upper and lower extremities. Yes / No
- c) Any limitation or derangement of a joint. Yes / No

C.N.S.

Pupillary Reflexes	Normal / Abnormal
Tendon/Reflexes	Normal / Abnormal
Cranial Nerves	Normal / Abnormal
Gross Sensory Disturbance	Yes / No
Paresis – Tremor or tics	Yes / No

C.V.S.

- a) Is pulse normal in rhythm and character? Yes / No
- b) Heart sounds normal Yes / No
- c) Pulse rate
- Systolic / Diastolic
- d) Blood Pressure (sitting or lying)

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RESPIRATORY:

Any abnormality on clinical exam Yes / No

DIGESTIVE SYSTEM AND ABDOMEN:

a) Abnormality of Oro Pharynx Yes / No

b) Any abnormality of spleen, liver or other abdominal organs Yes / No

c) Is a hernia present? Yes / No

GENITO URINARY:

Urine: Sugar Yes / No
Albumen Yes / No

SKIN:

Evidence of disease Yes / No
Body marks or scars (description please) Yes / No

OTHER:

Thyroid gland Normal Yes / No
Lymph glands Normal Yes / No
Speech defect Normal Yes / No

EXAMINER PLEASE COMMENT:

Is there anything unfavourable in the applicant's personality as revealed by history, appearance and behaviour? Yes / No

Is there any evidence of alcohol or drug abuse? Yes / No

Do you consider any further reports or Tests are required? Yes / No

The application IS / IS NOT fit without restriction for the issue of the Licence applied for.

SIGNATURE OF MEDICAL EXAMINER:

DATE:

ADDRESS:
.....
.....

Details:

Medical history and Examination record for persons applying to be licensed as a Jockey, to be permitted to ride as an Apprentice Jockey or to be registered as a Stablehand / Trackwork Rider.

SURNAME: GIVEN NAMES:
(Please Print) (Please Print)

ADDRESS:
.....

DATE OF BIRTH :

NAME AND ADDRESS OF NEXT OF KIN:
.....

PERSONAL HISTORY:

Have you ever suffered from – (Answer 'Yes' or 'No'). If 'Yes', give details.

1. Any Nervous Disability (including Nerves, Depression, Nervous Breakdown, Mental or Emotional Instability, Neurasthenia or anxiety State or Attempted Suicide?)
2. Headaches, Migraine?
3. Fits, Convulsions, Turns, Blackouts, Fainting, Giddiness, or Epilepsy?
4. Lung or Chest trouble, Pneumonia, Bronchitis, Asthma?
5. Heart Disease, Blood Pressure or Rheumatic Fever?
6. Indigestion, Pain after Meals, Gastric or Duodenal Ulcer, Hiatus Hernia, Gall Bladder Disease, Recurrent Diarrhoea, Appendicitis or Piles?
7. Kidney or Bladder Trouble, Cystitis, Stones?
8. Diabetes, Goitre, Thyroid Disease? Any Disease of Glands?
9. Anaemia or Blood Disease?
10. Perforated ear Drums, Deafness or Noises in the Ear, Earache or Ear Discharge, Blocked Ears?
11. Frequent Head Colds, Sinusitis, Blocked Nose, Hay Fever or Allergies?
12. Backache, Back Injuries, Spinal Problems, Neck injuries or Pains, Arthritis?