Name :

Address :

Medical Examination - To be downloaded and completed by an IHRB nominated doctor

Please complete below in block letters			
Date of examination:			
Name:		**Mr/Mrs/Miss/Ms:**	
Date of Birth:			
Height:		**Pulse Rate:**	
Weight:		**Blood Pressure:**	
Body Mass Index:		**Urine:**	

Central Nervous System:		
Pupils - size, equality and reaction	**Normal** ☐	**Abnormal** ☐
Reflexes - biceps, triceps, patella, achilles	**Normal** ☐	**Abnormal** ☐
Gait, rhomberg, co-ordination, touch, pinprick, vibration, proprioception	**Normal** ☐	**Abnormal** ☐
Speech and Hearing:		
Speech and hearing	**Normal** ☐	**Abnormal** ☐
Ear, Nose and Throat:		
Tympanic Membranes	**Normal** ☐	**Abnormal** ☐
Nose	**Normal** ☐	**Abnormal** ☐
Throat, teeth and gums	**Normal** ☐	**Abnormal** ☐
Eye System:		
Cornea, fundi, movement	**Normal** ☐	**Abnormal** ☐
Colour vision	**Normal** ☐	**Abnormal** ☐
Visual fields (confrontation)	**Normal** ☐	**Abnormal** ☐

Visual Acuity:	
Uncorrected	**Near Left ☐ Near Right ☐**
Corrected (soft lens only permitted when race riding)	**Near Left ☐ Near Right ☐**
Chest:	
Clear of scars and deformity	**Normal ☐ Abnormal ☐**
Percussion & auscultation	**Normal ☐ Abnormal ☐**
Breasts	**Normal ☐ Abnormal ☐**
Peak Flow (if necessary)	**Normal ☐ Abnormal ☐**
Cardiovascular System:	
Heart sounds	**Normal ☐ Abnormal ☐**
Peripheral pulses	**Normal ☐ Abnormal ☐**
Abdomen:	
Palpation	**Normal ☐ Abnormal ☐**
Hernial Orifices	**Normal ☐ Abnormal ☐**
External Genitalia (men only)	**Normal ☐ Abnormal ☐**
Cervical and dorso-lumbar movement	**Normal ☐ Abnormal ☐**
Shoulders and upper limbs	**Normal ☐ Abnormal ☐**
Hips and lower limbs	**Normal ☐ Abnormal ☐**
Grip strength	**Normal ☐ Abnormal ☐**
Muscle wasting, scoliosis, kyphosis, scars	**Yes ☐ No ☐**
Other abnormalities	**Yes ☐ No ☐**
If any abnormality above, please clarify below;	

IRISH HORSERACING REGULATORY BOARD
THE CURRAGH, COUNTY KILDARE , IRELAND, R56 Y668. TELEPHONE (+353 45) 445600 FAX (+353 45) 445601
EMAIL : info@ihrb.ie WEBSITE : www.ihrb.ie

Result:			
Examining doctor's opinion regarding the applicant's fitness to race ride			**Fit ☐ Unfit ☐**
I, the undersigned, hereby consent for the IHRB apppointed Medical Officer to obtain any further information he/she may deem necessary from my Family Doctor or other treating Physicians or Surgeons.			**Yes ☐**
Applicant's signature:		**Date:**	
Signature of IHRB Doctor:		**Tel No.:**	
Name of IHRB Doctor:		**Fax No.:**	
Email of IHRB Doctor:			
Address:			

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