



MEDICAL HISTORY FORM

(to be completed by applicant)

Personal Data:

| | | | |
|----------|------|-------------|---------------|
| Name: | | First name: | Date of birth |
| Address: | | | |
| Sex | male | female | FMN: |

| | | | |
|----|--|-----|---------|
| No | | Yes | Details |
|----|--|-----|---------|

Loss of consciousness for any reason dizziness or headache

Eye problems (except glasses)

Asthma

Allergy to medicines or drugs

Diabetes

Heart problems

Blood pressure disorder

Stomach problems (ulcer, etc)

Uro-genital problems

Epilepsy or convulsions

Mental or nervous disorder

Problems with arms or legs incl. muscle cramp or joint stiffness

Blood disorder with tendency to bleeding

Blood group

Operations

Do you take any medicine or drugs regularly?

If you take any medicine or drugs regularly, please list below the medicine or drugs:

- a. I have not been banned, on medical grounds, from taking part in any other sport.
- b. I do not take any prohibited substances and/or methods as per the WADA list and do not abuse alcohol.
- c. In case of an injury and/or illness I give permission to the Medical Staff to release any relevant information to the my relatives and my representatives.
- d. I will immediately inform the relevant FIM Medical Officer /FIM SBK Medical Director/FIM Medical Director/ Representative and the CMO of any changes in my health through illness or injury that may adversely affect my ability to ride or compete
- e. I declare that the information that I have given is the truth.
- f. I agree to the information on the Medical Examination Form being sent to the doctor of my FMN.

Date Signature of applicant (or responsible Parent or Guardian if a minor)

