

MEDICAL HISTORY FORM
(to be completed by the applicant)



Personal Data:

Name:	First name:	Date of birth:
Address:		
Sex	male female	FMN: AMA / CMA

No	Yes	Details
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Loss of consciousness for any reason dizziness or headache

Eye problems (except glasses)

Asthma

Allergy to medicines or drugs

Concussions (number/date)

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 type

Operations (fractures/hardware)

Do you take any medicine or drugs regularly?

- I have not been banned, on medical grounds, from taking part in any other sport.
- I do not take drugs and do not abuse alcohol.
- In case of an injury I give permission to the Medical Staff to release any relevant information to the clerk of the course, my relatives, my own doctor and the FMN.
- I declare that the information that I have given is the truth.
- 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)