MEDICAL CERTIFICATE

ALL SECTIONS MUST BE COMPLETED BY THE APPLICANT / PARENT / GUARDIAN

PERSONAL DETAILS

Surname: ______________First Name: _______________ Birth Date: __/__/__

Address: _____ ____

Sex: Male ☐ Female ☐ National Federation: _________

Medical History (to be completed by applicant or responsible parent or guardian if applicant is a minor): Circle where appropriate:

		DETAILS
Loss of, consciousness for any reason, dizziness or headache	YES/NO	________________
Eye trouble (except glasses)	YES/NO	________________
Asthma	YES/NO	________________
Allergy to medicines or drugs	YES/NO	________________
Diabetes	YES/NO	________________
Heart Trouble	YES/NO	________________
Blood pressure disorder	YES/NO	________________
Stomach trouble (ulster, etc.)	YES/NO	________________
Uro-genital trouble	YES/NO	________________
Epilepsy or convulsions	YES/NO	________________
Mental or nervous disorder	YES/NO	________________
Trouble with arms-or legs incl. muscle cramp or joint stiffness	YES/NO	________________
Blood disorder with tendency to bleeding	YES/NO	________________
Operations	YES/NO	________________
Do you take regularly medicine or drugs?	YES/NO	________________
Other illnesses	YES/NO	________________

a) I have not been banned! on medical grounds, from taking part in any other sport.

b) I do not take drugs and do not abuse alcohol.

c) In case of emergency, I authorise any qualified person to administer the necessary treatment, medical and or surgical, including the administration of blood or blood products. I also agree to information concerning my medical condition being given by the Doctor in Charge to the Clerk of the Course, and to my own doctor and relatives.

d) I declare that the information that I have given is the truth.

e) I agree to the information on the Medical Examination Form being sent to the doctor of my FMN.

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

____ Date:__/__/__

Mandatory Medical Examination

TO BE COMPLETED BY THE EXAMINING DOCTOR

	NORMAL	ABNORMAL	DETAILS (if abnormal)
Cardio-vascular system:	__________	__________	__________
Blood Pressure:	__________	__________	__________
Pulse:	__________	__________	__________
Respiratory system:	__________	__________	__________
Head	__________	__________	__________
Peripheral	__________	__________	__________
Ear, nose and throat, in particular vestibulocochlear apparatus:			
right	__________	__________	__________
left	__________	__________	__________
Locomotor system:			
Arm right	__________	__________	__________
Arm left	__________	__________	__________
Leg right	__________	__________	__________
Leg left	__________	__________	__________
Spine	__________	__________	__________
Abdomen (hernia)	__________	__________	__________

Eyes:

Distant vision

right __________

left __________ without correction

right __________

left __________ with correction (if worn)

Urine:

Albumen __________ __________ __________

Glucose __________ __________ __________

Any long-term medication ____

Any other comment:

____

____

☐ I, the undersigned, certify that this person is fit to take part in motorcycle events.

☐ I, the undersigned, certify that this person is NOT FIT to take part in motorcycle events.

☐ I recommend that this person be examined by a member of the Medical Committee of the M.C.I. or doctor appointed by the M.C.I.

(Tick which box applicable)

Date of examination: __/__/__

Signature and STAMP of Doctor: ________________________________