

MALTA MOTORSPORT FEDERATION PRE-COMPETITION MEDICAL FORM



Name _____ Surname _____ ID number _____

Address _____

TO BE FILLED IN BY THE APPLICANT – Medical Declaration

- Does the applicant have any allergies? YES NO
- Does the applicant take any regular medication? YES NO
- Has the applicant had any surgical procedures? YES NO
- Has the applicant failed a breathalyser test or suffer from alcohol problems in the past 12 months? YES NO

Has the applicant ever been diagnosed with and/or had treatment for the following:

- | | | | |
|-----------------------|--|---|--|
| Head injury | <input type="checkbox"/> YES <input type="checkbox"/> NO | Heart or lung disease | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Epilepsy | <input type="checkbox"/> YES <input type="checkbox"/> NO | Serious illness | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Fainting/blackouts | <input type="checkbox"/> YES <input type="checkbox"/> NO | High blood pressure | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Loss of consciousness | <input type="checkbox"/> YES <input type="checkbox"/> NO | Hospitalisation (within last 12 months) | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Asthma | <input type="checkbox"/> YES <input type="checkbox"/> NO | Diabetes | <input type="checkbox"/> YES <input type="checkbox"/> NO |

If you answer yes to any of the above questions please provide details below, including names of drugs and dosages currently taken:

- Does the applicant have any eyesight problems for distant vision? YES NO
- Is the applicant's eyesight correctable with glasses or contact lenses? YES NO

If you answered "Yes" please provide further details below:

Date of last Tetanus Injections (If not known, state so or state "date provided by applicant"): _____

Blood Group (including rhesus factor), if known: _____

I accept the conditions of, and acknowledge the risks arising from, attending or participating in the events provided/endorsed/facilitated by MMF and/or their Associated Entities. I certify that the statements made to MMF regarding my psychological and physical conditions and any previous illness are true and accurate. I declare that, should any of the above conditions become evident during the validity period of this licence, I agree to abstain from exercising the privileges granted to me in virtue of this licence and to notify MMF and/or their Associated Entities by submitting to further medical examination, the results of which are to be forwarded to MMF. I undertake not to use any drugs or medication that are considered illegal and/or use any drugs, medications or practices which contravene or are in the WADA Prohibited list or as per LN281 of 2011 and/or defined in the Anti-Doping Code of the SportMalta (SM) as the National Anti-Doping Organisation (NADO) and/or the Olympic movement, on the recommendation of the World Anti-Doping Agency (WADA). I agree to undertake any anti-doping analysis tests, including any test for alcohol that may be considered necessary by MMF. I authorise any hospital or medical practitioner to furnish information relevant to my medical condition to MMF's medical assessor in order to determine my fitness to compete and/or participate in such motorsport events. I understand and authorise the MMF to hold my personal information on its database for the purposes herein prescribed. If applying for professional status, I confirm that for the last tax year prior to this application, I declared my earnings as a competitor in motorsport and therefore request that the MMF endorse my licence with the word 'Professional' and further with the EU flag, in accordance with the FIA regulation 52.

For female applicants: I agree and declare that I shall abstain from taking part in any competition whilst pregnant.

Any applicant making a false declaration is liable to refusal and cancellation of licence and/or any insurance cover if applicable.

Applicant's signature _____ Guardian signature if under 18 _____ Date _____

Medical Examination – to be completed only by a Specialist in Sports and Exercise Medicine

Name _____ Surname _____ ID number _____

Address _____

Are you the regular medical attendant of the Applicant?

YES NO

Past medical history _____

Physical Examination

Height _____ Weight _____

Cardiovascular System:

Blood Pressure _____ / _____ mm/Hg

Pulse rate _____ bpm regular/irregular

Auscultation : S1+S2+ _____

Murmurs YES NO Type _____

Respiratory System:

Auscultation, Lung Fields _____

Gastro-Intestinal System:

Palpation _____

Genito-urinary System: Dipstick test: Protein _____ Glucose _____

Central Nervous System:

Vision Snellen's Chart A. Vision R eye ____ / ____ L eye ____ / ____ With correction if applicable R eye ____ / ____ L eye ____ / ____

Field of Vision R eye ____ / ____ L eye ____ / ____ Pupil reaction to L & A R eye ____ / ____ L eye ____ / ____

Colour vision: Normal/Abnormal _____ Ishihara plates not cleared _____

Hearing: Normal/Abnormal _____

Locomotor System:

Upper Limb: Abnormality YES NO

Power _____ Reflex _____

Lower Limb: Abnormality YES NO

Power _____ Reflex _____

Exercise Stress Test:

date of examination _____ / _____ / _____

Normal YES NO

Write list of Positive findings in applicant's medical history and examination

Does the applicant warrant further investigation and/or Follow up?

YES NO Explain below

Is applicant Cleared for competitive sports

YES NO

Doctor's name

Doctor's Mobile No.

Doctor's signature

Date of Examination

Doctor's STAMP

Any fee charged for completion of this examination or associated with it is the responsibility of the applicant