



FEDERAZIONE ITALIANA KICKBOXING MUAY THAI SAVATE e SHOOT BOXE

Pre-Match Declaration Form

Date and place of the competition:

Type of competition (ordinary, Championships)

Medical History Declaration

Athlete: Surname.....Name.....

Date and place of Birth Nationality.....

Membership N° Association/Club.....

Date of last match: Result.....

Date of last match in similar sport disciplines (boxing etc.) Result.....

	Yes	No
Have you ever had any of the following symptoms?		
1. Headaches	<input type="checkbox"/>	<input type="checkbox"/>
2. Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
3. Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>
4. Double or blurry vision	<input type="checkbox"/>	<input type="checkbox"/>
5. Fainting or <u>loss of consciousness</u>	<input type="checkbox"/>	<input type="checkbox"/>
6. Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Have you taken drugs or supplements in the last 90 days?	<input type="checkbox"/>	<input type="checkbox"/>
• If so, which ones:		
Have you been ill or had <u>any</u> traumas in the last 120 days?	<input type="checkbox"/>	<input type="checkbox"/>
• If so, which ones?		

Athlete's Signature or Legal Guardian:

In the case of minors, the Legal Guardian Mr./Ms. (along with a copy of Identification) attests that the information provided above is true and delegates the accompanying coach Mr./Ms. for any further correlated health & sanitary measures

Signature

Date

Signature of visiting Medical Doctor pre-Match

(Stamp and signature).....