



FIM AFRICA COMPETITOR MEDICAL INFORMATION FORM

All riders competing in FIM AFRICA EVENTS must complete this form, which will be held at Race Control for use by the Chief Medical Officer

COMPETITOR'S PERSONAL DETAILS															
FIM AFRICA PERMIT NO.					FIM LICENCE NO:			FMN LICENCE NO.							
SURNAME:					PASSPORT NO:										
FULL FIRST NAME(S):					FEDERATION										
RESIDENTIAL ADDRESS:															
HOME TEL NO:	+	EMAIL			MOBILE NO:										
CONTACT PERSON IN THE EVENT OF AN EMERGENCY															
NAME:					RELATIONSHIP (i.e. Father, Wife, etc.)										
HOME TEL NO:	EMAIL			CELL NO:											
MEDICAL AID / MEDICAL INSURANCE DETAILS FOR HOSPITAL ADMISSION PURPOSES															
<p>I hereby agree to be attended to by doctors/paramedics if I am injured and wish to be transported to the hospital identified for this event.</p>															
Do you have Competitors insurance through your Federation?								YES			NO				
Please list the maximum medical benefit for which you are insured through your FMN/Medical Insurer <i>(This is/should be listed on your licence, if your insurance is separate to your licence please ensure that your proof of insurance cover is handed in or email together with your competition licence and/or proof of medical aid cover in case of admission and copy of Passport at documentation).</i>								LIST AMOUNT OF COVER							
PERSONAL (HOME) DOCTOR:								CONTACT NUMBER:							
COMPETITOR MEDICAL INFORMATION															
MEDICATION/MEDICAL CONDITION(S):															
ALLERGIES:															
BLOOD GROUP															
HAVE YOU SUSTAINED A RECENT INJURY /ILLNESS:		YES			NO			IF YES, HAVE YOU BEEN CLEARED AS MEDICALLY FIT TO COMPETE? Please submit clearance from your FMN with this form. If No your entry cannot be accepted.		YES			NO		
<p><i>IF YOU TICKED YES AND HAVE YOUR CLEAANCE, PLEASE LIST RECENT INJURIES SUSTAINED:</i></p>															
<p><i>I/WE HAVE READ AND UNDERSTOOD THE FIM AFRICA GSR's AND EVENT SR's AND SIGNIFY MY/OUR AGREEMENT TO ABIDE BY THESE RULES BY SIGNING THIS MEDICAL FORM.</i></p>															
COMPETITOR SIGNATURE:					PARENT/LEGAL GUARDIAN IF UNDER 21 YEARS OF AGE										