

MEDICAL HISTORY FORM

(to be completed by applicant)



APPENDIX A

Personal Data:

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

No	Yes	Details
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<input type="checkbox"/> Loss of consciousness for any reason dizziness or headache	<input type="checkbox"/>
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<input type="checkbox"/> Eye problems (except glasses)	<input type="checkbox"/>
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<input type="checkbox"/> Asthma	<input type="checkbox"/>
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<input type="checkbox"/> Allergy to medicines or drugs	<input type="checkbox"/>
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<input type="checkbox"/> Diabetes	<input type="checkbox"/>
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<input type="checkbox"/> Heart problems	<input type="checkbox"/>
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<input type="checkbox"/> Blood pressure disorder	<input type="checkbox"/>
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<input type="checkbox"/> Stomach problems (ulcer, etc)	<input type="checkbox"/>
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<input type="checkbox"/> Uro-genital problems	<input type="checkbox"/>
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<input type="checkbox"/> Epilepsy or convulsions	<input type="checkbox"/>
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<input type="checkbox"/> Mental or nervous disorder	<input type="checkbox"/>
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<input type="checkbox"/> Problems with arms or legs incl. muscle cramp or joint stiffness	<input type="checkbox"/>
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<input type="checkbox"/> Blood disorder with tendency to bleeding	<input type="checkbox"/>
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Blood group

<input type="checkbox"/> Operations	<input type="checkbox"/>
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<input type="checkbox"/> Do you take any medicine or drugs regularly?	<input type="checkbox"/>
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- 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)



MEDICAL EXAMINATION FORM

(To be completed by doctor)

APPENDIX B

Personal Data:

Name:		First name:		Date of birth:	
Address:					
Sex:	male	female	FMN:		
Normal				Abnormal	Details (if abnormal)

<input type="checkbox"/>	Cardio-vascular system	
<input type="checkbox"/>	*Exercise tolerance ECG	
<input type="checkbox"/>	*Echocardiography	

<input type="checkbox"/>	Blood pressure	
<input type="checkbox"/>	Pulse	
<input type="checkbox"/>	Respiratory system	

<input type="checkbox"/>	Nervous system		
	central		
<input type="checkbox"/>	peripheral		

<input type="checkbox"/>	Ear, nose and throat, in particular vestibulo-cochlear apparatus		
	right		
<input type="checkbox"/>	left		

<input type="checkbox"/>	Locomotor-system		
	arm	right	
<input type="checkbox"/>		left	
<input type="checkbox"/>		leg	right
<input type="checkbox"/>			left
<input type="checkbox"/>		spine	

<input type="checkbox"/>	Abdomen (hernia)	
<input type="checkbox"/>	Urine	
	Albumen	
	Glucose	

	Eyes: Distant vision		
<input type="checkbox"/>	without correction	right	
<input type="checkbox"/>	with correction	left	
<input type="checkbox"/>	with correction	right	
<input type="checkbox"/>	color vision	left	
<input type="checkbox"/>	visual field		

*** In addition to the medical examination, an applicant for any licence in Cross-Country Rallies (World Championship, FIM Prize, international events) must undergo and pass successfully an echocardiogram once in his lifetime prior to the issuing of the licence. An exercise tolerance electrocardiogram must be conducted and successfully passed with this echocardiogram and is then required every three years.**

- I, the undersigned, certify that this person is medically fit to take part in motorcycle events
- I, the undersigned, certify that this person is medically NOT FIT to take part in motorcycle events
- I recommend that this person be examined by a member of the Medical Committee of the FMN, or doctor appointed by the FMN.

Date of examination

Signature and stamp of Doctor