



MEDICAL HISTORY FORM

(to be completed by applicant)

Personal Data:

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

No	Yes	Details
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Loss of consciousness for any reason dizziness or headache

Eye problems (except glasses)

Asthma

Allergy to medicines or drugs

Diabetes

Heart problems

Blood pressure disorder

Stomach problems (ulcer, etc)

Uro-genital problems

Epilepsy or convulsions

Mental or nervous disorder

Problems with arms or legs incl.muscle cramp or joint stiffness

Blood disorder with tendency to bleeding

Blood group

Operations

Do you take any medicine or drugs regularly?

If you take any medicine or drugs regularly, please list below the medicine or drugs:

- a. I have not been banned, on medical grounds, from taking part in any other sport.
- b. I do not take any prohibited substances and/or methods as per the WADA list and do not abuse alcohol.
- c. In case of an injury and/or illness I give permission to the Medical Staff to release any relevant information to the my relatives and my representatives.
- d. I will immediately inform the relevant FIM Medical Officer /FIM SBK Medical Director/FIM Medical Director/ Representative and the CMO of any changes in my health through illness or injury that may adversely affect my ability to ride or compete
- e. I declare that the information that I have given is the truth.
- f. 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 APPENDIX B
 (To be completed by doctor with reference to the FIM Medical Code,
 Art. 09.1.1 Guidelines for the examining doctor)

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"/>	
<input type="checkbox"/>	*Exercice tolerance ECG	<input type="checkbox"/>	
<input type="checkbox"/>	*Echocardiography	<input type="checkbox"/>	
<input type="checkbox"/>	Blood pressure	<input type="checkbox"/>	
<input type="checkbox"/>	Pulse	<input type="checkbox"/>	
<input type="checkbox"/>	Respiratory system	<input type="checkbox"/>	
<input type="checkbox"/>	Nervous system central	<input type="checkbox"/>	
<input type="checkbox"/>	peripheral	<input type="checkbox"/>	
<input type="checkbox"/>	Ear, nose and throat, right	<input type="checkbox"/>	
<input type="checkbox"/>	in particular vestibulo-		
<input type="checkbox"/>	cochlear apparatus left	<input type="checkbox"/>	
<input type="checkbox"/>	Locomotor-system arm right	<input type="checkbox"/>	
	left	<input type="checkbox"/>	
<input type="checkbox"/>	leg right	<input type="checkbox"/>	
	left	<input type="checkbox"/>	
<input type="checkbox"/>	spine	<input type="checkbox"/>	
<input type="checkbox"/>	Abdomen (hernia)	<input type="checkbox"/>	
<input type="checkbox"/>	Urine Albumen	<input type="checkbox"/>	
<input type="checkbox"/>	Glucose	<input type="checkbox"/>	
<input type="checkbox"/>	Eyes: Distant vision		
<input type="checkbox"/>	without correction	right	<input type="checkbox"/>
		left	<input type="checkbox"/>
<input type="checkbox"/>	with correction	right	<input type="checkbox"/>
		left	<input type="checkbox"/>
<input type="checkbox"/>	color vision		<input type="checkbox"/>
<input type="checkbox"/>	visual field		<input type="checkbox"/>

* In addition to the medical examination, an applicant for any licence in FIM Cross-Country Rallies WC 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.

Except in Trial an exercise tolerance electrocardiogram is required for riders aged 50 years and over.

- I, the undersigned, certify that I am this person/rider's medical practitioner and familiar with his/her medical history.
- I, the undersigned, certify that I know and am familiar with the WADA list of prohibited substances and prohibited methods
- I, the undersigned, certify that I have not prescribed any prohibited substances and/or prohibited methods to this person
- I, the undersigned, certify that I have prescribed prohibited substance(s) and/or prohibited method(s) to this person, providing that a TUE was agreed by the FIM and/or that no alternative treatment with authorised substance(s) was possible
- 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 commission of his/her FMN or doctor appointed by the FMN and of the FIM, if necessary.

Date of examination

Signature and stamp of Doctor