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.	XXX/25		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

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.

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 ***(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).***	**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** ☐

IF YOU TICKED YES AND HAVE YOUR CLEAANCE, PLEASE LIST RECENT INJURIES SUSTAINED:

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.

COMPETITOR SIGNATURE:		PARENT/LEGAL GUARDIAN IF UNDER **21** YEARS OF AGE	