

MOSTA CYCLING CLUB

Medical Certificate



Part One (To be filled in by applicant)

I (full name) _____ born on ____/____/____, request , to be examined with a view to assess my medical fitness to participate in **COMPETITIVE CYCLING***.

I declare that to the best of my knowledge, I suffer or have suffered from:

Hay Fever / Sinusitis	Fast / Irregular Heartbeat	Anemia / Heavy Menstruation
Ruptured Eardrum	High / Low Blood Pressure	Jaundice
Deafness / Blindness	Heart Trouble	Diabetes
Bronchitis / Pleurisy	Chronic Diarrhea / Ulcers	Serious Injury / Disablement
Pneumonia	Recurrent Headaches	Heavy smoking
Tuberculosis	Head Injury / Unconsciousness	Alcoholism / Drugs
Pneumothorax	Fits / Seizures / Blackouts	Regular Medication
Asthma	Sleeping Troubles	Other (Specify here-under)
Chest Pain	Nervous Breakdowns / Phobias	

Regular Medication	
--------------------	--

Other Remarks	
---------------	--

Part Two (To be filled in by Medical Practitioner)

REMARKS		REMARKS	
Blood Group		Cardiovascular System	
R. Ear Drum		Blood Pressure	
R. Eustachian Tube		Abdomen	
L. Ear Drum		CNS	
L. Eustachian Tube		Joints & Limbs	
R. Eye		Nose & Sinuses	
L. Eye		Mouth & Thorax	
Lung & Chest		Urinalysis	
C.X.R / Pulmonary Function		Personality/Mental Status	

Part Three

MEDICAL CERTIFICATE

I have today, the ____/____/____, medically examined _____,

I.D. Card Number _____, and certify that in my professional opinion, he / she is fit to take part in **COMPETITIVE CYCLING***.

Name of Medical Practitioner (in block letters)	
Medical Practitioner (rubberstamp)	
Signature of Medical Practitioner (to include Doctor's stamp with Medical Reg. No.)	
Signature of Cyclist (applicant / guardian)	

*Competitive Cycling – includes but is not only related to training – both indoors and outdoors and racing.