Health Declaration

PERSONAL PARTICULARS

Name:

Date of birth:

Address:

Contact Number:

Blood Group:

Gender:

Weight Category:

	Yes	No
Do you suffer from any clinical medical illness? (Diabetes/Asthma/Epilepsy etc.)		
Have you been treated in the hospital in the last 12 months?		
Do you suffer from communicable diseases?		
Have you ever been tested positive for HIV, Hepatitis B, or Hepatitis C?		
Are you wearing any prosthetic device in your mouth, ear, etc.?		

Please give further details on answers with "YES"!

I officially declare that I am fully responsible legally for my answers given above.

Date: Fighter Signature:

I have examined the above fighter and I have found him physically & mentally fit to participate in a competition.

Date: Doctor's signature with stamp & registration number: