**Form C2 - Player’s Medical Information**

**Delegation Name**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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First name

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Family Name

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| --- | --- | --- | --- | --- | --- |
| D | D | M | M | Y | Y |

Gender (M/F/X) Date of Birth

**Contact person in case of Emergency**

|  |  |
| --- | --- |
| Name |  |
| Address |  |
| Telephone (include country code and/or area code) |  |
| Mobile telephone (include country code and/or area code) |  |

Dietary restrictions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Health Information:

|  |  |  |  |
| --- | --- | --- | --- |
| History of: | YES | NO | comments |
| Down Syndrome |  |  |  |
| If Yes, x-ray done for check of ATLANTOAXIAL instability |  |  | Results: |
| Bleeding problem |  |  |  |
| Diabetes |  |  |  |
| Fainting Spells |  |  |  |
| Heart Problems |  |  |  |
| Recent Contagious Disease |  |  |  |
| Kidney Problem |  |  |  |
| Epilepsy (Seizures) |  |  |  |
| Visual Problem |  |  |  |
| Hearing Problem |  |  |  |
| Allergies |  |  | Please specify: |

**Immunizations** Tetanus Yes / No (Date / / ) Polio Yes / No  
**Medication** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Restrictions / Comments** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have examined the above-mentioned person, and certify, based on that examination, that there is no medical evidence, which would preclude the athlete’s participation in football at the Special Olympics European Unified Futsal Christmas Cup 2023 on 14-17 December, 2023 in Belgium.

Physician’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Signature Date \_ \_/ \_ \_/2023