WORLD ASSOCIATION
OF KICKBOXING ORGANIZATIONS

Medical Emergency Report

Event:	Date:	Time:

Name & Surname	Date of Birth:	ID-Nr./Nation

Address:	Tel.	Insurance-Nr.

Diagnosis / Injury and Physical Examination

History

Treatment

Sent to hospital / Contact with

For acceptance:

_____

Kickboxer's signature:

_____

Coach's signature

_____

Doctor's signature and stamp

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