WAKO MEDICAL QUESTIONNAIRE
SPORTS MEDICAL EXAMINATION

Event: _____

Please read the below information carefully, complete the requested information, date and sign under your name. This form must be completed and returned to a Medical Control official when registering.

Name: _____ **Sports ID:** _____

DOB: _____ **Country:** _____ **E mail address:** _____

Weight Class: _____ **kg** **Style:** _____

	Yes	No
Did you have any illnesses earlier?		
Were your born with any of your body parts missing?		
Have you ever been treated in hospital?		
Do you take any medicine on a regular basis?		
Do you take any food complementary substances?		
Have you ever fainted during or after training?		
Have you ever had any chest pain?		
Have you ever had high blood pressure?		
Have you ever had any skin diseases?		
Do you have any dermatological complaints at the moment?		
Do you suffer from asthma?		
Do you have any problems related to your bones, joints, tendons, or muscles?		
Have you ever had a skull injury accompanied with a loss of consciousness?		
Did you have headache in the past 10 days?		
Do you have teeth braces? If yes please attach the Dental Brace certification!		
Are you often on a diet		

Please give further details on answers with "Yes": _____

_____

_____

_____

I officially declare that I am fully responsible for my answers given above. I also declare that, pursuant to Regulation (EU) 679/2016 (GDPR), I am aware that the data collected through this document will be processed for the purposes described in WAKO Privacy Notice and that I have taken vision of the latter pursuant to art.13 GDPR.

Date _____ **Signature:** _____

For a kickboxer under the age of 18 signature of Parent or Legal Guardian: _____