

PLEASE COMPLETE IN BLOCK CAPITALS!

Athlete's Personal Data

LAST NAME AND FIRST NAME (FATHER'S/MOTHER'S NAME):	
DATE OF BIRTH:	
TELEPHONE / MOBILE NO.:	
ID CARD OR PASSPORT NUMBER:	

Sport's Club Information

CLUB NAME:	
SPORT:	
THE YEAR YOU STARTED TRAINING:	
COACH (FIRST NAME, LAST NAME):	
NUMBER OF TRAINING HOURS PER WEEK (INCLUDING COMPETITIONS):	

WE KINDLY REQUEST THE ATHLETE (OR PARENT/GUARDIAN) TO ANSWER THE FOLLOWING QUESTIONS

Family History (information about illnesses within the family)

Medical Condition	Answer	If YES, please provide details
Diabetes mellitus	☐ Yes ☐ No	
Epilepsy	☐ Yes ☐ No	
Heart disease	☐ Yes ☐ No	
Sudden cardiac death (within 3 generations of family members before the age of 50)	☐ Yes ☐ No	
High blood pressure (Hypertension)	☐ Yes ☐ No	
Stroke	☐ Yes ☐ No	
Vascular (blood vessel) diseases	☐ Yes ☐ No	
Nervous system diseases	☐ Yes ☐ No	
Musculoskeletal system diseases	☐ Yes ☐ No	
Cancer / tumors	☐ Yes ☐ No	
Autoimmune diseases (including juvenile arthritis and similar)	☐ Yes ☐ No	
Other diseases	☐ Yes ☐ No	

Information on Habits

Habit / Lifestyle	Frequency	If YES, please provide details
Regular diet / balanced nutrition	☐ Yes ☐ No ☐ Occasionally	
Regular sleep patterns	☐ Yes ☐ No ☐ Occasionally	
Consumption of alcoholic beverages	☐ Yes ☐ No ☐ Occasionally	
Use of nicotine products	☐ Yes ☐ No ☐ Occasionally	
Use of drugs / illicit substances	☐ Yes ☐ No ☐ Occasionally	
Use of medications	☐ Yes ☐ No ☐ Occasionally	
Use of dietary supplements	☐ Yes ☐ No ☐ Occasionally	

Do you suffer from / have you ever suffered from the following diseases/conditions?

Medical Condition	Answer	If YES, please provide details
Fainting / Syncope	☐ Yes ☐ No	
Dizziness / Vertigo	☐ Yes ☐ No	
Heart diseases	☐ Yes ☐ No	
Vascular (blood vessel) diseases	☐ Yes ☐ No	
Lung diseases	☐ Yes ☐ No	
Diabetes mellitus	☐ Yes ☐ No	
Thyroid diseases	☐ Yes ☐ No	
Neurological diseases	☐ Yes ☐ No	
Kidney diseases	☐ Yes ☐ No	
Urinary system diseases	☐ Yes ☐ No	
Prostate diseases	☐ Yes ☐ No	
Sexually transmitted diseases (STDs)	☐ Yes ☐ No	
Liver diseases	☐ Yes ☐ No	
Skin diseases	☐ Yes ☐ No	
Head injuries – concussion	☐ Yes ☐ No	
Spine diseases / injuries	☐ Yes ☐ No	
Joint diseases / injuries	☐ Yes ☐ No	

Extremity (arms/legs) diseases / injuries	☐ Yes ☐ No	
Congenital diseases / defects	☐ Yes ☐ No	
Allergies (including food intolerances)	☐ Yes ☐ No	
Asthma	☐ Yes ☐ No	
Infectious diseases	☐ Yes ☐ No	
Mononucleosis	☐ Yes ☐ No	
Visual impairment / vision disorders	☐ Yes ☐ No	
Hearing impairment / hearing disorders	☐ Yes ☐ No	
Mental health / psychiatric illnesses	☐ Yes ☐ No	
Anemia	☐ Yes ☐ No	
Alcoholism	☐ Yes ☐ No	
Narcolepsy	☐ Yes ☐ No	
Cancer / tumors	☐ Yes ☐ No	

During and/or outside of heavy physical exertion, I experience / have experienced the following symptoms:

Medical Condition	Answer	If YES, please provide details
Breathing difficulties / shortness of breath	☐ Yes ☐ No	
Have you needed to use a bronchodilator – inhaler? (question for athletes with asthma)	☐ Yes ☐ No	
Chest pain	☐ Yes ☐ No	
Dizziness / lightheadedness	☐ Yes ☐ No	
Palpitations (feeling of skipped heartbeats)	☐ Yes ☐ No	
Headaches	☐ Yes ☐ No	
Frequent muscle cramps	☐ Yes ☐ No	

Other Questions:

Have you ever undergone surgery?	☐ Yes ☐ No
If yes, which one:	
Have you ever been hospitalized?	☐ Yes ☐ No
If yes, when and for what reason:	
Do you use orthopedic aids?	☐ Yes ☐ No
If yes, which ones:	
Have you ever been declared unfit for a specific sporting activity?	☐ Yes ☐ No

☐ In accordance with Article 6 of Regulation (EU) 2016/679 on the protection of natural persons with regard to the processing of personal data, we collect and process your personal data solely for the purpose of assessing your medical fitness to participate in sports competitions

☐ I declare under criminal and material liability that I have conscientiously, responsibly, and truthfully completed this form, and that I have not withheld any fact or claim that could lead to a misunderstanding or incorrect conclusion.

 (Signature of athlete or signature of parent/guardian for minor athletes)

DECLARATION OF CONSENT FOR MEDICAL EXAMINATION

Information about the Parent / Guardian / Legal Representative

FIRST AND LAST NAME:	
OIB (Personal ID Number):	
ADDRESS:	
TELEPHONE / MOBILE NO.:	
E-MAIL ADDRESS:	

Information about the Athlete

FIRST AND LAST NAME:	
OIB (Personal ID Number):	
ADDRESS:	
SPORTS CLUB:	
CLUB CONTACT NUMBER:	

Statement by which I, as parent/guardian/legal representative, hereby grant consent for the performance of the medical examination, in compliance with the Ordinance on Medical Examinations of Athletes, for my minor child.

Place and Date: _____

 (Signature of parent / guardian / legal representative)