



MEDICAL CERTIFICATE (MF3)

For all competitors and all sporting events

Confidentiality and Security of personal Information

Personal information will not be used or disclosed for purposes other than those for which it was collected, except with the consent of the individual or as required by law. Personal information will be retained only as long as necessary for the fulfilment of those purposes. You may wish to provide information for research.

This form should be completed by the Physician who is in charge of your transplant follow-up. It must be completed and signed two (2) months before the commencement of the games and returned to the LOC Office one (1) month before the games.

I, Dr _____ Telephone _____ Email _____

Hereby certify the current state of health of Mr/Mrs/Ms _____

Date of Birth: ___/___/___ Organ Transplanted: _____ Date of Transplantation: ___/___/___

do certify that he/she does not show any contraindications * for participation in the following sporting activities

(List precisely which sports): _____: _____: _____:
_____: _____: _____

and that he/she has not experienced a major rejection episode within the last month

OR I confirm that he/she is not currently suitable *
Delete as appropriate

Cardiac Stress Test: Results to be completed by your Cardiologist or by the Physician who is in charge of your transplant follow-up. Note that the stress test is strongly recommended and should be dated less than four (4) months before the start of the event for heart transplant and heart and lung transplant recipients and less than six (6) months in all recipients if partaking in a high stress sports. Coronary angiograms may be required if the stress test is abnormal.

I, Dr _____ Telephone: _____

Confirm that I have witnessed the stress test and blood pressure profile carried out on

Mr/Mrs/Ms _____ Dated: _____

With reference to the Stress Tests, please document the following:

Date of the Test: ___/___/___ (enclose a copy of the test)

Maximum strength tolerated and duration: _____

Percentage of maximal theoretic frequency: _____

Reason for stopping test: _____

Result of ECG race (1) without irregularity
With irregularity

Resting pulse and maximal: _____

Signed by _____ on the _____
(Name) (Date)

_____ (Signature)
Stamp:

SURNAME

GIVEN NAME

MEDICAL RECORD (MF4)

This information is requested from the Physician who is in charge of your transplant follow-up. The form must be completed and signed 2 months before the event and returned to the LOC Office one (1) month before the event.

Please Note: This information will be carefully scrutinised prior to the competitor's registration. If the information provided is incomplete, the athlete will not be permitted to register

COMPETITOR'S DETAILS

First Name: _____ Last Name: _____

Date of Birth: ___/___/_____ Address: _____

Emergency Contact Telephone number: _____; Mobile: _____

Email: _____ Next of Kin: Name: _____ Ph No: _____

Date of Transplant: ___/___/_____; Type: kidney; lung; heart; liver; bone marrow; pancreas

Current Medications (all): *Please attach complete list including complementary medicines*

Allergies/Diet		Competitor's Height	
		Competitor's Weight	

LABORATORY DATA

Creatinine (<300) *		Alkaline Phosphatase	
Haemoglobin (>10hm/dl)		FK/Cyclosporine Level	
ALT		Hepatitis B	+ -
AST		Hepatitis C	+ -
Bilirubin		Blood Sugar	

* Higher acceptable if stable

CARDIO-VASCULAR AND RESPIRATORY STATUS

History of High Blood Pressure	YES / NO		
Coronary artery disease: results of the most recent coronary angiogram or cardiac isotopic scan and date			
Baseline Blood Pressure (<150/90)	Lying		Standing
Ejection fraction of left ventricle (EFLV)			
Rhythm abnormalities:			
Pulmonary function (if lung disease)	Vital Capacity		

OTHER MEDICAL PROBLEMS eg diabetes mellitus

MEDICAL ADVISOR'S DETAILS

Name: _____ Signature: _____ Date: _____

Address: _____

Telephone: _____ Fax: _____ Email: _____

SURNAME

GIVEN NAME