VETERAN MEDICAL CERTIFICATE

Article 5.1 of the General Regulations for the World Championships Veteran provides:

"Each wrestler shall pass a medical examination in his own country, one week before the competition start date. A UWW Veteran Medical Certificate should be filled and signed by a certified doctor. This form must be delivered to UWW doctor of the competition at the pre-weighing medical examination".

UWW EVENT

Competitions: ....

Place / Date: ....

WRESTLER

Surname: .... First Name: ....

Date of Birth (Day/Month/Year): .... /.... /.... Sex: ☐ Male ☐ Female

Nationality: ....

Address: ....

....

E-mail: .... Phone Number: ....

MEDICAL ASSESSMENT SUMMARIES

1. General Examination:

A- Medical History:

☐ Normal ☐ Abnormal - Please specify:

....

....

....

....

....

VETERAN MEDICAL CERTIFICATE

B- Routine Lab Tests:

Hemoglobin, Hematocrit, Erythrocytes, Thrombocytes, Leukocytes, C-reactive Protein, Glucose, Creatinine, Uric Acid, Triglycerides, Cholesterol (total, LDL, HDL), Creatine phosphokinase, Sodium, Potassium, Calcium, Phosphor, Urine Analysis

☐ Normal ☐ Abnormal - Please specify:

....

....

....

....

C- Skin Inspection:

☐ Normal ☐ Abnormal - Please specify:

....

....

....

....

D- General Health:

☐ Normal ☐ Eligible to wrestle with considerations ☐ Non-eligible to compete

Please specify: ....

....

....

....

....

....

Examining Doctor:

Surname & Name: .... Date: ....

Address: ....

Signature:

2. Cardiovascular Examination

Physical examination, Chest x-ray, Heart rate & rhythm, Blood pressure, Electrocardiography, Echocardiography

☐ Normal ☐ Eligible to wrestle with considerations ☐ Non-eligible to compete

Please specify: ....

....

....

....

....

Examining Doctor:

Surname & Name: .... Date: ....

Address: ....

Signature:

---

3. Orthopedic Examination

Spine (cervical, thoracic, lumbar), Shoulder, Arm, Elbow, Forearm, Wrist, Hand, Fingers, Hip, Thigh, Knee, Lower leg, Ankle & Foot

☐ Normal ☐ Eligible to wrestle with considerations ☐ Non-eligible to compete

Please specify: ....

....

....

....

....

Examining Doctor:

Surname & Name: .... Date: ....

Address: ....

Signature:

VETERAN MEDICAL CERTIFICATE

Medical Certification

I certify that this wrestler:

☐ Has no apparent contraindication to practice wrestling at competitive level.

☐ Is not recommended to practice wrestling at competitive level.

☐ Normal ☐ Eligible to wrestle with considerations ☐ Non-eligible to compete - Please specify:

....

....

....

....

....

Certifying Doctor:

Surname & Name: .... Date: ....

Medical Registration Number: ....

Address: ....

Phone Number: .... Fax Number: ....

E-mail: ....

Signature & Stamp:

UWW Doctor Approval

☐ Medical Certificate Approved.

☐ Medical Certificate is not approved.

Surname & Name: .... Date: ....

Signature: