



MALTA FOOTBALL ASSOCIATION
MEDICAL CLEARANCE FORM

PHYSICIAN USE ONLY

Outcome of screening

Date: _____

Player: _____

Club: _____

Gov.ID No: _____

Comet ID No: _____

YES

NO

Is the player medically fit to compete and train at high-performance level?

Are there any medical issues that warrant further assessment?

Physician's name: _____

Official stamp:

Signature: _____

E-mail address: _____

A copy of this form must be presented to the Malta Football Association

MEDICAL CLEARANCE FORM

I do hereby certify that I have today received the Medical Clearance Form of player _____

MFA ID Card No _____ with _____ F.C.

Date: _____

MFA Reception _____



MALTA FOOTBALL ASSOCIATION
PLAYER MEDICAL INFORMATION

Name: Club:

Date of Birth: Govt Id Card No:

MFA Id Card No:

Address:

Telephone No: Mobile:

Email:

Doctor's Name:

Consent:

I agree to undertake this procedure in order to enable medical staff to ensure I am fit to train and compete.

I am aware that some information may require clarification or follow-up with the treating physician and possibly, other specialists and agree to the release of relevant information to those people.

Date: _____

Signature: _____

Parent/Guardian signature if under 18 years of age: _____

PHYSICIAN EXAMINATION

GENERAL:

Radial and Femoral Pulses

Marfan Stigmata

Findings

CARDIAC AUSCULTATION:

Rate

Rhythm

Murmur: Systolic/Diastolic

Systolic Click

	/min
	mmHg

BLOOD PRESSURE:

DIAGNOSTIC TESTS

This applies only for post-pubertal children, adolescents and adults 12-lead rest ECG:

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