Id-Dar tal-Providenza
Homes of Persons with Disabilities

53 HOUR VOLLEYBALL MARATHON 2025

Medical Examination Form

1. Participant Details

Full Name: ____

ID number: ____________________ DOB: ____________________

Mobile no: ____________________

Emergency Contact Name & Number: ______________________________

Height: __________ Weight: __________ Do you smoke? Yes/NO

Current Medications or Supplements/Vitamins: __________________________

Allergies to Medications/Food/Other: ______________________________

2. Medical History (to be completed by participant)

Please tick ✓ any conditions you currently have or have had in the past:

Condition	Yes	No
Asthma, shortness of breath during exercise or other respiratory conditions	☐	☐
Heart condition, heart murmur, palpitations or chest pain	☐	☐
High or low blood pressure	☐	☐
Diabetes	☐	☐
Fainting spells or dizziness	☐	☐
Head injury or concussion		
Bone/joint/muscle injuries	☐	☐
Epilepsy or seizures	☐	☐
Condition requiring admission to hospital	☐	☐
Family history of sudden collapse or sudden death	☐	☐
Other (please specify): __________	☐	☐

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If you ticked YES to any of the above, please provide details:

____

____

Signature of athlete: ________________________________ Date: ____________________

Signature of legal guardian: __________________________ Date: ____________________

(if applicant is under the age of 18)

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3. Physical Examination (to be completed by examining physician)

Test/Observation	Reading (where applicable)	Normal	Abnormal
Blood Pressure		☐	☐
Heart Rate		☐	☐
Cardiovascular System		☐	☐
Respiratory System		☐	☐
Musculoskeletal System		☐	☐
Vision and Hearing		☐	☐
Neurological Signs		☐	☐

Notes: ____

____

4. Doctor's Declaration

Based on the above assessment, I confirm that the participant IS / IS NOT (cross off as appropriate) medically fit to participate in the training leading up to and the 53-Hour Volleyball Marathon in aid of Dar Tal-Providenza

Additional Recommendations/Restrictions (if any):

____

5. Doctor's Details and Signature – only doctors registered in Malta can sign this declaration

Name of Medical Practitioner: ____

Registration Number: _________________________ Signature:____________________________

Date: ___________________

Please note – Improperly filled or uncompleted medical forms will NOT be accepted