



# Self-Declaration Medical Form

## Part 1 – Applicants’ Information

Name: \_\_\_\_\_ Age: \_\_\_\_\_  
 Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 City / Province: \_\_\_\_\_ M \_\_\_ F: \_\_\_ Wear Glasses: Y \_\_\_ N: \_\_\_  
 Date of Birth: D: \_\_\_\_\_ M: \_\_\_\_\_ Y: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Email Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 In Case of Emergency: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

## Part 2 – Applicants’ Medical Self-Declaration

Conditions:	Yes	No
Frequent or severe headaches		
Unconsciousness for any reason		
Dizziness or fainting spells		
Epilepsy or Seizures		
Heart Trouble:		
Coronary Artery Disease or Angina		
Valve disease		
Abnormal Cardiac Rhythms		
High Blood Pressure		
Psychiatric/Mental Health Problems		
Operation(s) involving Eyes, Brain, Heart, Nerves, Blood Vessels, or Bones		
Allergies		
Eye trouble (except for glasses)		
Asthma		
Diabetes		
Anemia, or other blood diseases including abnormal bleeding		
Admission to a hospital in the past 12 months		
Amputations and/or Physical disability		
Previous denial(s) due to a medical reason(s)		
Date of last Tetanus Shot.		

List all Medications (include dosage and frequency taken)

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## Part 3 – Applicants’ Declaration

1. I declare that the information regarding my present state of health, given to the examining physician is correct.
2. I agree to be re-examined as follows:
  - a. Upon the expiration of my current medical as required by the current competition rules.
  - b. Following any significant illness, injury or hospitalization.
3. I give permission to any hospital, institution or physician to furnish my medical information to WCMA.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

(If applicant is under the age of majority)