

# NEW DELHI YMCA DEPARTMENT OF SPORTS

## MEDICAL CERTIFICATE (To be certified by an M.B.B.S. Doctor)

TO TAKE PART IN (Sports Activity) .....

CANDIDATE'S NAME..... AGE..... SEX.....

HEIGHT.....(cms.) WEIGHT.....(kgs.) HEART RATE...../Minute. BLOOD PRESSURE(S/D) .....

### STATE WHETHER THE CANDIDATE HAD/HAS: (GIVE DETAILS)

#### I. SKIN INFECTION SUCH AS BACTERIAL / VIRAL / FUNGAL OR ANY OTHER COMMUNICABLE DISEASES

Eye..... Throat.....

Ear..... Skin & Abdomen.....

(IF ANY: GIVE DETAILS) .....

#### II. CNS..... CVS.....

RESPIRATORY SYSTEM..... LIVER.....

SPLEEN..... HERNIA SITES.....

THROAT..... SINUS.....

#### III. HISTORY OF EPILEPSY, DIZZINESS, ASTHMA, TB, VD, ALLERGY, DIABETES, HEART PROBLEMS, WATER PHOBIA

(IF ANY: GIVE DETAILS) .....

#### IV. ANY ABNORMALITY / PHYSICAL DEFECT AS DISABILITY SUCH AS KYPHOSIS, SCOLIOSIS, KNOCK KNEES, FLATFOOT,

OBESITY (IF ANY: GIVE DETAILS) .....

#### V. (a) PREVIOUS FRACTURE/JOINT DISLOCATION INJURIES/MUSCULAR INJURIES

(IF ANY: GIVE DETAIL) .....

(b) SPONDYLITIS..... (c) ARTHRITIS.....

I HEREBY CERTIFY THAT I HAVE EXAMIN Mr. / Ms. ....

S/o / D/o MR .....on (date) .....AND HAVE

RECORDED MY OBSERVATIONS AS ABOVE. I AM SATISFIED THAT HE / SHE IS FIT / NOT FIT FOR .....

.....WHICH INVOLVES STRENUOUS PHYSICAL ACTIVITY.

(DOCTOR'S SIGNATURE)

NAME OF THE DOCTOR : .....

REGN. NO : .....

TELE. NO : .....

DOCTOR'S STAMP

CANDIDATE'S SIGNATURE