LUCHA ESP
FEDERACIÓN ESPAÑOLA DE LUCHA

Date of the form
/ /

MEDICAL FORM

FIGHTER'S INFORMATION

Name and Surname(s) :
(PLEASE, IN CAPITAL LETTERS)

Data of birth : _____/_____/_____ **Gender** : ☐ Male ☐ Female

License number : _____ **Name of the Club** : _____

DETAILS OF THE INCIDENT

Data of the incident : _____/_____/_____ **City** : _____

Doctor's name and surname(s) :

Collegiate number : _____

Loss of consciousness : ☐ YES ☐ NO **If the answer is yes, how long?** : _____

Observed symptoms : _____

_____

To fill in to compete again

MEDICAL AUTHORIZATION

I certify that the fighter has respected the return to sport protocol, that he is asymptomatic and that, therefore, he is fit to resume the competition.

Doctor's name and surname(s) :

Collegiate number : _____ **Signed on** : ____/____/____ **in** : _____

Signature :

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Clause: This form must be sent to the federation before the resumption of any competition.