



Alberta Taekwondo Association Medical Fitness to Compete

This form **MUST BE COMPLETED** or your Application to compete will **NOT** be accepted.

Name _____ Date of Birth _____ Phone _____

Address _____ AHC# _____

1. I hereby certify that I have not suffered a concussion, head injury, loss of consciousness or blow to the head followed by dizziness, memory loss or headache **in any activity** in the past 30 days.

Signed _____

Under 18 years, Legal Guardian _____

Date _____

2. Have you suffered a head injury, loss of consciousness, concussion or blow to the head in the past 6 months?

_____ YES _____ NO

3. If **YES**, what symptoms did you have **after** the injury?

___ dizziness	___ blurred vision	___ amnesia	___ feeling in a fog
___ tingling	___ headache	___ irritability	___ ringing in the ears
___ numbness	___ nausea	___ vomiting	___ sensitivity to light
___ inability to concentrate		___ seeing flashing lights	

4. Of the above symptoms, do you still experience any of these?

_____ YES _____ NO