



MALTA FOOTBALL ASSOCIATION  
**MEDICAL CLEARANCE FORM**

**PHYSICIAN USE ONLY**

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Outcome of screening

Date: \_\_\_\_\_

Player: \_\_\_\_\_

Club: \_\_\_\_\_

Gov.ID No: \_\_\_\_\_

Comet ID No: \_\_\_\_\_

YES

NO

Is the player medically fit to compete and train at high-performance level?

Are there any medical issues that warrant further assessment?

Physician's name: \_\_\_\_\_

Official stamp:

Signature: \_\_\_\_\_

E-mail address: \_\_\_\_\_

***A copy of this form must be presented to the Malta Football Association***

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**MEDICAL CLEARANCE FORM**

I do hereby certify that I have today received the Medical Clearance Form of player \_\_\_\_\_

MFA ID Card No \_\_\_\_\_ with \_\_\_\_\_ F.C.

Date: \_\_\_\_\_

MFA Reception \_\_\_\_\_



MALTA FOOTBALL ASSOCIATION  
**PLAYER MEDICAL INFORMATION**

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Name:  Club:

Date of Birth:  Govt Id Card No:

MFA Id Card No:

Address:

Telephone No:  Mobile:

Email:

Doctor's Name:

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**Consent:**

I agree to undertake this procedure in order to enable medical staff to ensure I am fit to train and compete.

I am aware that some information may require clarification or follow-up with the treating physician and possibly, other specialists and agree to the release of relevant information to those people.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Parent/Guardian signature if under 18 years of age: \_\_\_\_\_



# PHYSICIAN EXAMINATION

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## GENERAL:

Radial and Femoral Pulses

Marfan Stigmata

Findings

## CARDIAC AUSCULTATION:

Rate

Rhythm

Murmur: Systolic/Diastolic

Systolic Click

/min
mmHg

## BLOOD PRESSURE:

## DIAGNOSTIC TESTS

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This applies only for post-pubertal children, adolescents and adults 12-lead rest ECG:

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