

**MEDICAL FORM
CYCLOSPORTIVES**

n° Ident GT:

Name : First Name :
Sex (M/F) : Date of birth : / /
Address :
Zip Code : City :
Country : Tel : e-mail :

Please send the following certificate stamped and signed by your doctor :

I undersigned doctor :

Certify having examined Mr., Mrs., Miss :

And find him capable of participating in competitive

Date, stamp and signature are obligatory.

PARENTAL AUTHORISATION

(for any inscription of minor from 14 to 17 years)

I, the undersigned, Mr/Mrs/Miss/Ms.....(name)

Of(address)

Authorise my son/daughter.....(name), (M/F)

to participate in the cyclo-sportif organised by TOP CLUB and SPORT COMMUNICATION.

I have taken note that it is up to me to obtain, for my son/daughter, the accident/injury insurance of my choice. (To this effect, I have filled in the registration form, including: licence, insurance, and medical insurance).

In case of an accident, please inform.....(name)

.....(telephone number).

I here by authorise that all the information contained here in is true.

Date and Signature.

Read and approved.