World Transplant Games Federation
Powered by the gift of life

Transplant Athlete Medical Form
2024 Transplant Football World Cup, Cervia, Italy

Please note that you should **only use this form for collecting your medical data. All medical data must be submitted for each individual online here:** **Transplant Football World Cup Online Medical Form**

You MUST input all the data online in order to complete your registration to the 2024 Transplant Football World Cup.

You MUST visit the Doctor-in-charge of your transplant follow-up in order to get your accurate medical data and ensure that your Doctor is happy for you to compete in the Transplant Football World Cup. Completion of these forms confirms that you have indeed visited your doctor to obtain this information.

Steps to follow:

1. Download and print the medical form to aid you in collecting information needed to fill online
2. Visit your transplant follow up doctor to obtain the medical information required
3. Complete the medical forms online here: https://form.jotform.com/World_Transplant/transplant-football-world-cup
4. ***Forms must be completed online; no paper forms will be accepted.***
5. **Medical Forms must be completed before 26 July.**

The information on your medical forms will be reviewed prior to confirmation of your ability to compete. If the information is incomplete, you will not be allowed to participate in the World Cup.

Before competing in the Transplant Football World Cup, it is expected that your general health and fitness are stable as judged by your transplant follow-up doctor. Your health is to be measured by the tests performed by your follow-up doctor and, if necessary, your follow-up cardiologist or sports doctor. You are responsible for maintaining your own training program, preferably in conjunction with a sporting advisor/coach.

Football is considered a "high stress" level sport.

COMPETITOR DETAILS

***Team Country:** _____

***First Name:** _____

***Last Name:** _____

***Date of Birth: (dd/mm/yyyy)** _____

***Gender:** *(circle)* Male Female Other

***Home Address:** _____

_____

_____

***Email:** _____

***Mobile:** _____

***Emergency Contact name** _____

***Emergency Contact relationship** _____

***Emergency Contact number:** _____

TRANSPLANT DETAILS

***Date of transplant** _____

***Type of Transplant:**

Bone marrow/ Stem cell	Yes	No	(*from a donor)
Double Lung	Yes	No	
Heart	Yes	No	
Heart/lung	Yes	No	
Intestine	Yes	No	
Kidney	Yes	No	
Liver	Yes	No	
Single Lung	Yes	No	

Pancreas	Yes	No
Pancreas and Kidney	Yes	No
Pancreas Islet Cell	Yes	No
Other (please specify	_____	

FITNESS INFORMATION

***I certify that I take part in regular physical activity as follows**:

_____ times per week

_____ minutes per session

***I am training at a stress level of (circle):** Low Medium High

I take part in the following sports for leisure / competitively:

_____

_____

_____

MEDICATION

***Please complete the Table below:**

Name of Medication	Dose	Frequency

MEDICAL INFORMATION

***Are you pregnant**	**Yes**	**No**
***Are you on anticoagulants**	**Yes**	**No**
***Do you have diabetes mellitus**	**Yes**	**No**
***Do you have ischaemic heart disease**	**Yes**	**No**
***Do you have epilepsy**	**Yes**	**No**
***Do you have asthma**	**Yes**	**No**
***Have you had a heart or lung operation**	**Yes**	**No**

If yes, please provide more details _____

***Are you allergic to any medication**	**Yes**	**No**

If yes state _____

***Are you allergic to anything else**	**Yes**	**No**

If yes state _____

LABORATORY DATA

Results of all tests are required.
All results should be from tests performed **after** 01 March 2024

Test	**Result**	**Unit of measurement**	**Date of test**
***Creatinine / eGFR:** (Glomerular Filtration Rate)			
***Haemoglobin**			
***Blood sugar**			
ALT – *Liver Recipients only*			
AST– *Liver Recipients only*			

Bilirubin – *Liver Recipients only*			
Alkaline Phosphatase – *Liver Recipients only			
HbA1c (if diabetic)			

Hepatitis B (HBsAg)	**Yes**	**No**
RESULT of Hepatitis B (HBsAg)	Positive	Negative

Hepatitis C (anti-HCV)	**Yes**	**No**
RESULT of Hepatitis C (anti-HCV)	Positive	Negative

Cyclosporine level (target): _____

Tacrolimus Level (target): _____

CARDIO-VASCULAR & RESPIRATORY STATUS

***Baseline Blood Pressure (<150/90)** _____

***History of High Blood Pressure:** *(circle)* YES NO

Pulmonary function (HEART/LUNG, LUNG TRANSPLANT ONLY)

FEV1: _____

Vital Capacity: _____

CARDIAC STRESS TEST

A cardiac stress test is recommended for all recipients, especially those with a history of coronary artery disease or over the age of 50.

Will you be completing a cardiac stress test: *(circle)* **YES** **NO**

If you selected NO *– you will be required to a tick a box on the online forms, which say that you understand and accept the risk of not performing the stress test as recommended.*

Cardiac Stress Test Results:

Maximum Strength tolerated and duration: _____

Percentage of maximal theoretic frequency: _____

Reason for stopping test: _____

ECG – rhythm abnormality: *(circle)* YES NO

Resting pulse and maximal: _____

****You will be required to upload a copy of your Cardiac stress test results***

For those with an abnormal stress test, please supply results of the most recent coronary angiogram or cardiac isotopic scan and date.

Procedure	Date	Results

Ejection fraction of left ventricle (EFLV) REQUIRED FOR CARDIAC TRANSPLANT RECIPIENTS: _____

Rhythm abnormalities: _____

MEDICAL DOCTOR'S DETAILS

***Medical Doctor Name:** _____

***Hospital / Institute:** _____

***Address:** _____

_____

_____

***Telephone:** _____

***Email:** _____

***Date of consultation:** _____

*** Doctor Signature:** _____

I confirm that my medical doctor carried out an examination at the date of consultation indicated above, agreed I am fit to compete in my selected events, and provided me with all the medical information required in this document.

DECLARATION:

*I confirm that the information provided is true and accurate to the best of my knowledge and, where required, information is provided by a qualified medical doctor {tick}

***Electronic Signature:** _____

***Date:** _____

Please do not forget that ALL MEDICAL FORMS must be COMPLETED ONLINE