Medical Certificate

Participant Name _____

Full Address _____

Date of Birth _____

Consultation date _____

This is to certify that I the undersigned, Dr/Medical Professional _____ ,

Can confirm that _____ , shows no medical reason on file to prevent him/her taking part in a long distance ultra-marathon.

If there are medical reasons preventing the patient from taking part please state them below. If there are medical conditions/allergies we need to be aware of please state them below. If there are Religious beliefs which affect treatment please also state them below.

Existing Medical Condition/Allergy	Does condition affect participation in event?	Action required, i.e. medication

Signed _____

Name _____

Medical Practice Address/Stamp