Pre-Entry Fitness Medical Clearance Form

This document is to be correctly filled-in and endorsed by all applicants wishing to be considered for the following MCAST programmes of study

Foundation Certificate in Sports
Diploma in Sports
Diploma in Sports
Extended Diploma in Foundation Studies for Security, Enforcement and Protection
Advanced Diploma in Sport (Development, Coaching and Fitness)

This is an integral part of the process leading to the eligibility or otherwise to the course. Document is also required from those applicants who will be progressing from one level to the next through a Form B

A scan of the filled-in document must be uploaded together with the online application submitted during the Main Call for FT Course Admissions, closing on Monday 25 August 2025. With this document (duly endorsed as required) not uploaded on application, the application cannot be processed and vetted for eligibility.

The **Original hardcopy** version of the filled-in and signed document is ALSO to be (physically) submitted at the Reception Desk, Institute of Community Services, Main Campus, Paola, ***by not later than Monday 29th September 2025***.

Kindly refer to email ics@mcast.edu.mt or through phone **2398 7550** for any clarifications which may be required in relation to this form.

Not submitting a scan of this filled-in document as an upload with your application, and eventually submitting at ICS Reception Desk a signed hardcopy of same, by the set deadline, will indicate that you are no longer interested in having your application processed further.

History Form

This part of the document is to be filled in by the person applying for any of the Sports courses listed above

If under 18 years of age, Parent / Legal Guardian consent is required prior to visiting the Physician who will fill in and endorse the remaining part of the document

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Name and Surname: _____

ID Number: _____ Date of Birth: _____

Tick accordingly:

Age: _____ yrs ☐ Male ☐ Female ☐ Other

General Questions

Do you have any ongoing medical condition/s? If so, please identify below:

☐Asthma ☐Anaemia ☐Diabetes ☐Contagious Infections

Other _____

Has your doctor restricted your participation in sports? **If so, please state why**

Have you ever been hospitalised, or undergone surgery? **If so, please give details**

Do you have any allergies**? If yes, please identify specific allergy below:**

☐Medicines ☐Pollen ☐Food/Drinks ☐Stinging insects

Allergy: _____

Is your Tetanus immunisation status up to date? **If no, please give details**

Health related Questions Tick ✓ if	**Yes**	**No**
Have you ever passed out during or after exercise?		
Have you ever had chest pains during exercise?		
Does your heart ever race or skip beats (irregular beats) during exercise?		
Has a doctor ever told you that you suffer from any of the following? **Please tick all that apply.** ☐High blood pressure ☐High cholesterol ☐A heart murmur Other _____		
Do you tire more quickly than friends during exercise?		
Do you get lightheaded during exercise?		
Has any family member or relative died of heart problems or a sudden death before age 50?		
Do you feel short of breath more quickly than your friends during exercise?		
Do you cough, wheeze or have difficulty breathing during or after exercise?		

Health related Questions Tick ✓ if	**Yes**	**No**
Have you ever used an inhaler or taken asthma medication?		
Have you ever suffered from a seizure?		
Have you ever had a head injury or concussion?		
Do you have headaches during exercise?		
Have you ever had injury that required x—ray, MRI, CT scan, injections, therapy, a brace, a cast or crutches? **If so, please underline those that apply.**		

Have you had problems with your eyes or vision?		
Do you wear contact lenses or protective eyewear?		
Do you wear dental brace?		
Have you ever been ill while exercising in the heat?		
Do you get frequent muscle cramps during exercise?		
Have you ever had any broken, fractured bones or dislocated joints?		
Have you ever had an injury to muscle, ligament or tendon that caused you to miss training, game or competition? ***If so, please explain below.***		
Do you have a bone, muscle, or joint that bothers you? ***If so, please explain below.***		
Do any of your joints become painful, swollen, feel warm or look red? ***If so, please explain below.***		
Do you wear any assistive device, such as a brace, hearing aid etc.? ***If so, please explain below.***		
Has anyone recommended that you gain weight or lose weight?		
Do you worry about your weight?		
Have you ever had an eating disorder?		

Explain here any answers for which you have ticked a **'Yes'.**

I hereby state that, to the best of my knowledge,
my answers to the above questions are complete and correct.

Applicant's Signature: _____ Date Signed: _____

Parent/Guardian's Signature (if applicant is under 18 years): _____ Parent/Guardian's ID Number: _____

Physical Examination Form

This part of the Document, is to be filled out by a medical practitioner in view of participation in physical activities

If under 18 years of age, Parent / Legal Guardian consent is required prior to visiting the Medical Practitioner who will fill in and endorse

Name of Applicant:			
Date of birth:		ID:	
Date of exam:		□ Male □ Female □ Other	
Height (m)		Weight (kg):	
Pulse Rate/min:		Blood Pressure/mmHg:	

DIAGNOSES of....	Normal	Comments on Abnormal Findings
Visual acuity: (20/20)		
Eyes: Pupil Reactivity. Pupils equal		
Hearing		
Skin (Infectious dermatoses)		
Genitourinary (males only)		
Abdomen (Ornanomegaly)		
Respiratory (Exercise induced asthma)		
Cardiac Consultation	**Normal**	**Comments on Abnormal Findings**
Heart: Murmurs, Rhythm, Simultaneous Radial and Femoral Pulse, Systolic Click		
Musculoskeletial	**Normal**	**Comments on Abnormal Findings**
General body appearance		
Cervical Range of motion		
Shoulder function (Internal and eternal rotation)		

Elbow/ Forearms		
Wrist/hand/fingers		
Hip/knees /ankles (Functional: Duck walk)		
Knee extension and patellar tracking		
Foot/toes		
Back (Scoliosis)		

☐ Cleared for all physical activities without restriction

☐ Cleared for all physical activities without restriction after completing recommendations for further evaluation or treatment for:

☐ Not Cleared for physical activities

Reason/s:

I have examined the above candidate and completed the physical examination form. If conditions arise after the candidate has been cleared for participation, the physician may withdraw the clearance until the problem is resolved and potential consequences are fully explained to the candidate, and parent's/guardian's as required.

Name of Physician (Block Letters) _____

Address: _____

Phone:_____Date: _____

Signature of physician: _____

Stamp:

This section is only applicable for persons with disabilities

If under 18 years of age, Parent / Legal Guardian consent is required prior to visiting the Medical Practitioner who will fill in and endorse

Name of Applicant:		
Date of birth:		ID:
Date of exam:		□ Male □ Female □ Other

General Questions	
Type of Disability	
Classification (if available)	
Cause of disability (birth, disease, accident, other)	
Sport (s)	

Health related Questions Tick ✓ if	**Yes**	**No**
Do you require the use of brace, assistive device or prosthetic for sports? *If so, please explain below.*		
Do you use a hearing aid? *If so, please explain below.*		
Do you have a visual impairment? *If so, please explain below.*		
Do you suffer from autonomic dysreflexia *If so, please explain below.*		
Have you had muscle control disorder? *If so, please explain below.*		
Do you have frequent seizures that cannot be controlled by medication? *If so, please explain below.*		

Do you have headaches during exercise? *If so, please explain below.*		

Explain here any answers for which you have ticked a **'Yes'.**

Have you ever had any of the following ? Tick ✓ if	**Yes**	**No**
Have you ever been diagnosed with Atlantoaxial instability? *If so, please explain below.*		
Dislocated joints (more than one) *If so, please explain below.*		
Easy bleeding and bruising *If so, please explain below.*		
Osteopenia or osteoporosis *If so, please explain below.*		
Difficulty controlling bowel and bladder *If so, please explain below.*		
Numbness or tingling in arms or hands, legs or feet *If so, please explain below.*		
Weakness in arms or hands, legs or feet *If so, please explain below.*		
Recent change in coordination and ability to walk *If so, please explain below.*		
Spina Bifida *If so, please explain below.*		

Explain here any answers for which you have ticked a **'Yes'.**

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Applicant's Signature:		Date Signed:	
Parent/Guardian's Signature (if applicant is under 18 years):		Parent/Guardian's ID Number:	