MEDICAL EMERGENCY REPORT

Event:	Date:	Time:
Name & Surname:	**Date of Birth:**	**ID-Nr./Nation**
Address:	**Tel.**	**Insurance-Nr.**

Diagnosis / Injury and Physical Examination:

History:

Treatment:

Sent to hospital / Contact with:

For acceptance:

_____
Kickboxer's signature

_____
Coach's signature

_____
Doctor's signature and stamp

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