10th NATIONAL PENCAK SILAT CHAMPIONSHIP 2022-23

Singa/Macan/Pre-Teen/Sub-Junior/Junior(Boys&Girls)

Held On -13TH To 16TH JANUARY 2023

Competition Venue: - District Sports Complex, Shri Guru Govind Singh Jii Stadium,Nanded , Maharashtra,

REGISTRATION / PARTICIPATION FORM

DETALIS AS PER PASSPORT/ AADHAR CARD

Latest picaffix hereduly cross signed by the applicant

IPSF REGISTRATION NUMBER : -- ______________________________

FULL NAME:-____

PARENT NAME:-____

DATE OF BIRTH :- ____

PRESENT ADDRESS :____

____

PERMANENT ADDRESS: ____

____

IDENTIFICATION MARK :-____

MOBILE / WHATS APP NUMBER:-____________________________________

EMAIL ID : - ____

AADHAR CARD/ PASSPORT DETAILS :- PASSPORT NO: __________________

DATE OF ISSUE :_________________

DATE OF EXPIRY: __________________

PLACE OF ISSUE : __________________

GENDER:-__________HEIGHT :-__________ CM, WEIGHT ______________Kgs BLOOD GROUP ________

MEDICAL:- Please state any medical condition/ illness which you may have that your coach/ athlete may need to be aware of and requires you to apply for a Therapeutic Use Exemption(TUE)...(Medical certificate duly investigated by medical authority in enclosed with this form.) No, Athlete is allowed to play without the medical clearance certificate.

I understand that by signing this for that I am fully responsible for all the mis-happening or any kind of Injury during the championship and I am fully agree to be bound by the Constitution, Regulations, bye-laws and policies of the Indian Pencak Silat Federation with jurisdiction and control over the competition. I am playing in and that I am also bound by the Indian Pencak Silat Federaion Rules and Regulations by virtue of being deemed to be a 'Person' as defined in those regulations.

____
Signature of Player

____
Signature of the Coach

____
Signature of the Parent/Guardian

____
Signature of the State Secretary

____
Signature of the District Secretary

____
Signing Date

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COMPULSORY HEALTH CERTIFICATE

Affix cross-signed recent photograph

PART A: (TO BE FILLED BY APPLICANT)

1. Name ______________________________ S/o;D/o; W/o ____

   Address ____

2. Date of Birth ___________________ Identification mark: __________________ Blood Group:____________

3. **DECLARATION: Have you suffered from or have history of any of the following:**

a) Breathlessness	☐ Yes ☐ No	b) Diabetes	☐ Yes ☐ No
c) Respiratory/ lung ailment	☐ Yes ☐ No	d) High Blood pressure	☐ Yes ☐ No
e) Blood disorder	☐ Yes ☐ No	f) Asthma	☐ Yes ☐ No
g) Bleeding tendencies	☐ Yes ☐ No	h) Epilepsy	☐ Yes ☐ No
i) Heart ailment	☐ Yes ☐ No	j) Nervous breakdown	☐ Yes ☐ No
k) Joint Pains	☐ Yes ☐ No	l) High altitude/mountain sickness	☐ Yes ☐ No
m) Discharge from ear	☐ Yes ☐ No	n) History of stroke/ paralysis	☐ Yes ☐ No
o) Are you a smoker	☐ Yes ☐ No	p) Are you pregnant: (*applicable to female* **s).**	☐ Yes ☐ No

q) History of Heart Attack; if yes, please specify____________________________________

r) History of sudden death in family members; if yes, please specify_____________________

s) Any major injury in the past; if yes, please specify_________________________________

t) Any other ailment; if yes, please specify____

u) History of surgery; if yes, please specify____

v) Are you undergoing under any medication; if yes, please specify______________________

w) Are you allergic to drugs, foods and chemicals; if yes, please specify__________________

4. I hereby declare that the particulars given above are true to the best of my knowledge and belief, and nothing has been concealed.

Date_________ **(Signature/ thumb impression of the Applicant)**

PART B: (TO BE FILLED BY AUTHORISED MEDICAL AUTHORITY)

On the basis of information furnished by the applicant, detailed examination and the necessary investigations, it is certified that **Mr. / Ms./ Mrs.** ______________________________ **is fit for the participation in the Pencak Silat championship**

Details of any specific test conducted before issuing the certificate: ________________________

Name of the Doctor____

Designation:__________________ **nature and seal of Authorized Medical Authority**

Date of issue:__________________ **MCI/ State Medical Council Registration No:**_______________