M-6 Referee Health Control Form

FAMILY NAME	FIRST NAME	WEIGHT (kg)	HEIGHT (cm)	BODY MASS INDEX	BLOOD PRESSURE (mm Hg)	VISUAL ACUITY			VISUAL FIELD		HEARING	
						RIGHT	LEFT	BOTH	RIGHT	LEFT	RIGHT	LEFT
					/							
					/							
					/							
					/							
					/							
					/							
					/							
					/							
					/							
					/							
					/							
					/							
					/							
					/							
					/							
					/							
					/							
					/							
					/							
					/							
					/							
					/							
					/							

DATE:	NAME OF MEDICAL DOCTOR:	SIGNATURE: