 **WT Medical Observation Form**

***\** Indication: For any athlete who had moderate to severe head trauma by the opponent
during the competition with any of following symptoms:**

**(1) loss of consciousness / (2) altered mental status
(3) nausea/vomiting/headache/dizziness / (4) knockout(RSC)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** |  | **Time** |  |
| **Competition / Round** |  |
| **Full Name of the Injured athlete** |  |
| **Country of Origin** |  | **WT GAL No.** |  |
| **Weight Category** |  | **Sex** |  |
| **Nature of head trauma** |  |

**※ Check below form every 15minutes, up to 1 hour at venue medical room**

|  |  |  |  |
| --- | --- | --- | --- |
| **Time** | **Blood Pressure** | **Pulse Rate** | **Glasgow Score** |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |
|  |  |  |  |

**Attestation**

\* Date (DD/MM/YY)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, the undersigned **Official Medical Director,** of

the certify that I have examined and observed the

injured athlete, Mr/Ms for one hour in conformity with

the WT Medical Code. Currently, he/she presents no neurological abnormality or signs suggesting

medical emergency. Hereby, I will transfer the care of the injured athlete to

(Team physician/Head of team/Coach), for

observation. This athlete shall have suspension due to head trauma per WT Medical Code.

Signature of OMD Signature of Team Official

 (Head of Team / Coach / Team Medical Staff)

**\*This form must be filled in by OMD and submitted to**
(1) WT Medical Chair (frank@docdueren.de),
(2) Technical Delegate
(3) WT Sport Department (sport@worldtaekwondo.org)