

## **Declaration Form for Participation in Sports Meet 2026**

(To be Submitted by all learners)



### **Personal Details**

Name:

Enrollment Number:

Learner's Support Centre:

Age:

Contact Number:

### **Declaration**

I, \_\_\_\_\_ (name), hereby declare that:

1. I am voluntarily participating in the sports meet 2026 organized by Sreenarayananaguru Open University (SGOU).
2. I have been informed of the nature of the activities and competitions involved.
3. I am in good physical and mental health to participate in the events. I take full responsibility for assessing my fitness level for such participation.
4. I will abide by the rules and regulations of the event and follow the instructions provided by the organizers.
5. I understand that the university will take necessary safety measures; however, I will not hold the organizers responsible for any injury, accident, or unforeseen circumstances that may occur during my participation.
6. I undertake to inform the organizers immediately in case of any discomfort or health issues during the event.

Signature of the Learner:

Date:

Emergency Contact Details:

Name of Contact Person:

Relationship:

Contact Number:

# CERTIFICATE OF MEDICAL FITNESS

*(To be filled by all learners)*



## PERSONAL DETAILS

1. Name of the Learner: \_\_\_\_\_

2. Date of Birth & Age: \_\_\_\_\_

3. Gender: \_\_\_\_\_

4. Height: \_\_\_\_\_ 5. Weight: \_\_\_\_\_

6. BP: \_\_\_\_\_ 7. Pulse: \_\_\_\_\_

8. Cardiovascular System:

9. Central nervous System:

10. Musculoskeletal System:

11. Any Surgeries or procedures done:

If yes please specify \_\_\_\_\_

12. Has this person been diagnosed or taken treatment for cancer or Psychiatric illness: If yes please specify \_\_\_\_\_

13. In case of women,

Please specify whether pregnant or not - Yes/No

## CERTIFICATE

*(To be issued by a doctor not below the rank of a Civil Surgeon)*

Certified that \_\_\_\_\_ aged \_\_\_\_\_ having date of birth \_\_\_\_\_

\_\_\_\_\_ is physically and mentally fit to participate in SGOU Sports

Meet 2026. He/She is not suffering from communicative diseases at present.

Name of the Practitioner:

Signature:

Registration Number:

Stamp / Seal:

Date:

Place: