

**Certificat médical handisport**

Je soussigné(e), Docteur \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ CERTIFIE AVOIR EXAMINE CE JOUR :

 Nom et Prénom : \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ Date de naissance : \_ \_ / \_ \_ / \_ \_ \_ \_ Sexe : Masculin Féminin

Et n’avoir constaté AUCUNE CONTRE‐INDICATION à la pratique sportive des sports de triathlon adaptés (course à pied, vélo, natation) de compétition de loisir

Remarques restrictives éventuelles : \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

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Cachet professionnel : Signature du médecin :