

AMATEUR CONTESTANT'S MEDICAL EXAMINATION - PART 1

TO BE COMPLETED BY A LICENSED MEDICAL DOCTOR ONLY
Forms completed by a physician assistant or a nurse practitioner will NOT be accepted

Medical Allergies _____
Are you taking any medication? YES NO; EXPLAIN _____
Previous Hospitalization(s) or surgery (Give dates) _____

Results of the following blood tests must be attached to this application:
 Hepatitis B surface ANTIGEN
 Hepatitis C ANTIBODY
 HIV ANTIBODY

ALL MEDICAL AND LAB TEST RESULTS MUST BE DATED, SIGNED AND TAKEN NO

Answer All Questions Below:

- | | | | |
|---------------------------------|--------|------------------------------|--------|
| (A) BLEEDING TENDENCIES | YES NO | (L) SEIZURES AND CONVULSIONS | YES NO |
| (B) DIABETES | YES NO | (M) ASTHMA | YES NO |
| (C) HERNIA | YES NO | (N) HIGH BLOOD PRESSURE | YES NO |
| (D) HEART DISEASE | YES NO | (O) TUBERCULOSIS | YES NO |
| (E) SICKLE CELL DISEASE | YES NO | (P) MONONUCLEOSIS | YES NO |
| (F) KIDNEY DISEASE | YES NO | (Q) RHEUMATIC FEVER | YES NO |
| (G) HEPATITIS | YES NO | (R) COUGH | YES NO |
| (H) SKIN DISEASE | YES NO | (S) PSYCHIATRIC PROBLEMS | YES NO |
| (I) HEADACHES | YES NO | (T) CONTACT LENSES | YES NO |
| (J) JOINT INJURY OR DISLOCATION | YES NO | (U) NUMBER OF TIMES KO'D | _____ |
- (K) CONCUSSION/UNCONSCIOUSNESS YES NO (V) KIDNEY LUNG TESTICLE EVE REMOVED YES NO
(circle all requiring a YES response)

Do you have any other information concerning your health, past or present, which is NOT COVERED by the questions above? _____

A PERSON AGE 36 OR OLDER MUST ALSO SUBMIT A FAVORABLE:
 EEG (Electroencephalography) AND
 EKG (Electrocardiogram)

EXAMINING MD or DO NAME (Please print) _____
MEDICAL LICENSE # _____
(Must be licensed in a State, District or Territory of the United States)
ADDRESS _____ CITY _____
STATE _____ ZIP _____ PHONE NUMBER _____
MD or DO SIGNATURE _____ DATE _____
CONTESTANT SIGNATURE _____ DATE _____

CONTESTANT NAME (Please Print) _____

AMATEUR CONTESTANT'S MEDICAL EXAMINATION - PART 2

EARS

AUDITORY CANALS RIGHT _____ LEFT _____
DRUMS RIGHT _____ LEFT _____
AUDITORY ACUITY FOR CONVERSATIONAL VOICE RIGHT _____ LEFT _____

NOSE (note deformity, old fractures, deviated septum, other)

OROPHARYNX

TONSILS _____ GUM _____ TEETH _____
TONGUE (record any deviation or tremors) _____
NECK (note masses, pulse, thyroid, carotid, bruits, and limitation of motion)

THORAX

LUNGS _____
HEART (size, murmurs, arrhythmia) _____
HEART RATE _____ BLOOD PRESSURE (S) _____ (D) _____
PULSE RATE _____ IMMEDIATELY AFTER 20 HOPS _____
2 MINUTES AFTER EXERCISE _____

ABDOMEN

NOTE SCARS _____
LIVER, KIDNEY, SPLEEN (enlarged, tender) _____
INGUINAL AREA (tenderness, hernia) _____

SKIN (note staph infection, cyanosis, hair distribution)

LYMPHATIC SYSTEM _____

MUSCULOSKELETAL SPINAL SYSTEM (curvature, posture, tenderness, limitation of motion)

EXTREMITIES (deformity, tenderness, joint mobility) _____

NEUROLOGICAL

GAIT _____ RHOMBERG _____
FINGER TO NOSE _____ KNEE JERKS _____
BICEP JERKS _____ BABINSKI _____
BRUDZINSKI _____ CRANIAL NERVES _____
OTHER NEUROLOGICAL ABNORMALITY _____

I hereby certify that I have examined _____
(Please print contestant's name)

Date of the exam: _____ , _____
Month Day Year

I HAVE APPROVED THIS PERSON TO PARTICIPATE IN A COMBATIVE SPORTS EVENT.

MD or DO SIGNATURE _____ DATE _____

CONTESTANT SIGNATURE _____ DATE _____

CONTESTANT NAME (Please Print) _____

**** OPHTHALMOLOGIC MEDICAL EXAM ****

Exam with dilation must be done by an OPHTHALMOLOGIST or OPTOMETRIST

EXAMINATION (normal – N; abnormal - X)	RIGHT EYE	LEFT EYE
VISUAL ACUITY (WITHOUT CORRECTION)	N _____ F _____	N _____ F _____
EXTERIOR EXAM	_____	_____
ANTERIOR EXAM	_____	_____
FUNDI	_____	_____
EXTRAOCULAR MUSCLES	_____	_____
VISUAL FIELDS (Confrontation)	_____	_____
TONOMETRY	_____	_____

EXPLAIN ABNORMAL FINDINGS _____

DIAGNOSIS _____

I hereby certify that I have examined _____
(Please print contestant's name)

Date of the exam: _____ , _____ , _____
Month Day Year

I HAVE APPROVED THIS PERSON TO PARTICIPATE IN A COMBATIVE SPORTS EVENT.

Ophthalmologist or Optometrist NAME _____
(Please print)

LICENSE # _____
(Must be licensed in a State, District or Territory of the United States)

ADDRESS _____ CITY _____

STATE _____ ZIP _____ PHONE NUMBER _____

OPHTHAMOLOGIST or
OPTOMETRIST SIGNATURE _____ DATE _____

CONTESTANT SIGNATURE _____ DATE _____