AMATEUR COMBATIVE SPORTS CONTESTANT REGISTRATION
(Including Physical Exam & Eye Exam)

Submit All medical exams & test results with this registration

PLEASE PRINT CLEARLY

Association Name_____

First Name, Middle Name, Last Name (MUST BE LEGAL NAME)

Mailing Address

City, State, Zip

Home Phone (_____) _____ **Social Security # _____**

(Foreign Nationals may submit Passport #)

Date of Birth _____ **Place of Birth _____**

(City & State or Country if not U.S. Citizen)

Email Address _____

Amateur Affidavit

I certify under penalty of perjury, that I have not participated in any Combative Sports Event, for profit or as a professional.

By signing this registration form, I certify that all information is true and correct. I understand that providing false information on this registration may result in sanctions up to and including denial or revocation of the registration.

Contestant Signature _____ Date_____

CONTESTANT NAME (Please print) _____

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 MORE THAN 6 MONTHS BEFORE THE REGISTRATION IS SUBMITTED.

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, EYE 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** _____	**N** _____
	F _____	**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** _____