

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) _____

**** 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 _____