

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 _____

<p>I hereby certify that I have examined _____ (Please print contestant's name)</p> <p>Date of the exam: _____ , _____ Month Day Year</p> <p>I HAVE APPROVED THIS PERSON TO PARTICIPATE IN A COMBATIVE SPORTS EVENT.</p> <p>Ophthalmologist or Optometrist NAME _____ (Please print)</p> <p>LICENSE # _____ (Must be licensed in a State, District or Territory of the United States)</p> <p>ADDRESS _____ CITY _____</p> <p>STATE _____ ZIP _____ PHONE NUMBER _____</p> <p>OPHTHAMOLOGIST or OPTOMETRIST SIGNATURE _____ DATE _____</p> <p>CONTESTANT SIGNATURE _____ DATE _____</p>
