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

**Submit all medical exams & test results with this registration**

**PLEASE PRINT CLEARLY**

**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 _____**

**Event Information: Association Name_____**

**Amateur Affidavit**

**I certify under penalty of perjury, that I have not participated in any Combative Sports Event, for profit or as a professional._____ (Initials required)**

**By signing this application, 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 I am requesting, and in the imposition of administrative penalties.**

**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** (circle all requiring a YES response) | **YES NO** |

**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** _____