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_____ Event Date_____

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	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 _____