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 (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 ____________