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 BEFORE THE REGISTRATION IS SUBMITTED.

Answer All Questions Below:

(A) BLEEDING TENDENCIES YES NO
(B) DIABETES YES NO
(C) HERNIA YES NO
(D) HEART DISEASE YES NO
(E) SICKLE CELL DISEASE YES NO
(F) KIDNEY DISEASE YES NO
(G) HEPATITIS YES NO
(H) SKIN DISEASE YES NO
(I) HEADACHES YES NO
(J) JOINT INJURY OR DISLOCATION YES NO
(K) CONCUSSION/UNCONSCIOUSNESS YES NO
(L) SEIZURES AND CONVULSIONS YES NO
(M) ASTHMA YES NO
(N) HIGH BLOOD PRESSURE YES NO
(O) TUBERCULOSIS YES NO
(P) MONONUCLEOSIS YES NO
(Q) RHEUMATIC FEVER YES NO
(R) COUGH YES NO
(S) PSYCHIATRIC PROBLEMS YES NO
(T) CONTACT LENSES YES NO
(U) NUMBER OF TIMES KO'D ______
(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 __________