World Kickboxing Association

Comprehensive Pre-bout Physical Examination Report

Full Name (Last,First, MI) Ring Name Telephone# D/O/B

Address City State Zip Code

Name, Location, & Date of Event Division (Muay Thai, Kickboxing, MMA,etc

Medical History: Have you ever had or do you currently have any of the following conditions? Please check boxes of all that apply.

1. Bleeding Disorder		16	Hepatitis	
2. Seizure or Convulsions		17	Diabetes	
3. Rheumatic Fever		18	Physical Impairment	
4. Asthma or Shortness of Breathe		19	Skin Disease or Rash	
5. High blood Pressure		20	Chronic Cough	
6. Heart Disease		21	Headaches	
7. Tuberculosis		22	Swollen Joint, Joint Injury, or Dislocation	
8. Sickle Cell Disease		23	Spitting or Coughing of Blood	
9. Kidney, Lung, Testicle or Eye Removed		24	Surgery or Hospitalization	
10. Kidney Disease, Single or Horseshoe Kidney		25	Substance abuse	
11. Concussion or Unconsciousness		26	Communicable Disease	
12. Mononueleosis		27	Fracture	
13. Allergies		28	Rupture or Hernia	
14. Blurring of Vision		29	Dizziness or Fainting Spells	
15. Wear/have worn Glasses or Contact lenses		30	Rheumatism or Arthritis	

Name of Primary Care Physician / Family:_____

Do you have any other information concerning your health, past or present, which is not covered by the above questions? (if yes, describe fully)

Are you taking any Medications or Drugs?_____Please list and give the names of the prescribing doctor. _____

Date of Last Fight:_____/_____/_____
How many knock outs have you suffered? KO_____TKO_____Date of last KO___/____/____
Longest duration of unconsciousness_____(# of min, hour,days)
Length of time before returning to contact_____
Have you ever been knocked unconscious in any other sport or activity?_____
What is your average non-fight weight?_____

Applicant:

I declare that all of the above mentioned information is true and that I have not intentionally misrepresented any facts about my past or current medical history. I understand that the history and physical is provided as a screening tool for my d\safety. It does not replace annual and regular examinations by a primary care physician or family physician. I certify "I have been cleared for general pugilistic sports activity by my regular physician". I authorize the WKA and/or its representatives (which include, but are not limited to, Ringside physicians and/or State Athletic Commissions) to photocopy this record and maintain it on file which may include its addition to a National Medical Database or registry for Pugilistic Sport participants.

I release all of my medical records, by all of my treating physicians and hospitals, which may include medical history, findings, diagnoses, diagnostic test results, and prognoses.

I further release, promise to hold harmless, and convenant not to sue the ringside physicians, and/or agents, institutions or firms providing the information, which I have released.

I sign this waiver voluntarily and of my own will.

_____ ___/___/____
Participate Date

_____ ___/___/_____
Parent or Legal Guardian if under 18 Date

_____ ___/___/_____
Reviewed By Date

Physical Exam: To be completed by the physician (a check or no entry indicates normal findings)

Weight_____BP_____P_____RR_____Temp_____
General appearance:_____
HEET _____
Pupils: Reg_____Round_____Equal_____React Light_____Accom_____
Acuity: OD_____OS_____Periorbital Scars_____
Oropharynx:_____

Neck: LA_____Goiter_____ROM:_____
Lungs:_____
Heart:_____
Abd:_____
Inguinal Region _____
Ortho:_____Extremities:_____Spine ROM:_____Small Joints:_____
Skin:_____
Neuro:_____
Gail:_____Rhomberg:_____FNF:_____RAM:_____
Muscle Stretch Reflexes:_____Motor:_____Sensory:_____
Orientation: Self, Time, Place:_____

Signature of Physician:_____Date:__/__/___

NOTE: ALL WOMEN PARTICIPANTS MUST HAVE PROOF OF NEGATIVE PREGNANCY TEST