



# World Kickboxing Association



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Richmond, Virginia

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www.WKAUSA.com

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Attention Fighter:

Listed below are the requirements for fighters on all WKA-sanctioned cards. Please print your physical form and this cover letter and take them to your physician:

- Fighter physical - please fill out the first page of your physical BEFORE going to the doctor's office. This is the page where you fill in your medical history for the doctor to review before he/she completes the examination on the subsequent page (amateur) or pages (professional). Physicals missing the portion to be completed by the fighter will NOT be accepted.
- Bloodwork - you must have the following three bloodwork tests with negative results: HIV, Hepatitis B Surface Antigen, and Hepatitis C Antibody.
- Physicals and bloodwork must be faxed directly to the WKA at (804) 977-6249 from the doctor's office and/or lab. Fighters are advised to keep hard copies for themselves, but the medical providers must send the documentation to the WKA. Physicals and bloodwork should NOT be sent to us by the fighter, coach, or promoter.
- All medicals must be received **NO LATER** than two weeks before your fight.

## Physicians' Guide:

### Physical:

- ALL pages of the physical must be filled out and included. Please ensure that the fighter has filled out the first page of the physical and that you have reviewed it so that you are familiar with the fighter's medical history **before** completing the examination portion and that you fax the physical in its entirety.
- Please remember to fill in the fighter's name on each page of the physical.
- Please date the physical with the examination date next to your signature.
- Please remember to check the box/bubble that indicates whether or not the fighter is cleared to participate. A completed physical alone does not necessarily indicate to us whether or not a fighter is medically fit to participate - thus, we have included a box that you can check to indicate this.

### Bloodwork:

- All fighters must have negative blood test results for HIV. An oral swab is NOT sufficient.
- All fighters must have negative blood test results for Hepatitis B Surface Antigen. Other tests, such as Hepatitis B Surface Antibody or Hepatitis B Envelope Antigen are NOT sufficient. ALL fighters must have this test, regardless of whether or not they have been immunized.
- All fighters must have negative blood test results for Hepatitis C Antibody.

### Sending a Fighter's Physical/Bloodwork:

- Physicals and bloodwork must be faxed directly to the WKA at **(804) 977-6249** from the doctor's office and/or lab. Fighters are advised to keep hard copies for themselves, but the medical providers must send the documentation to the WKA.

If you have any questions, please e-mail our administrative office at admin@wkausa.com



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## Comprehensive Amateur Physical Examination Report

### Front To be Completed by Fighter

Name of Event: \_\_\_\_\_ Date of Event: \_\_\_\_\_  
 First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB: \_\_\_\_\_  Male  Female  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Country: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
 Email: \_\_\_\_\_ \*\* Will receive WKA Fighter License via email  
 Do you have a Health Insurance?  yes  no If so, with what company? \_\_\_\_\_

#### Medical History:

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

1. Blood Disorder or Anemia		19. Hepatitis	
2. Seizure or Convulsions		20. Diabetes	
3. Rheumatic Fever		21. Physical Impairment	
4. Asthma or Shortness of Breath		22. Skin Disease or Rash	
5. High Blood Pressure		23. Chronic Cough	
6. Heart Disease or Heart Murmur		24. Headaches	
7. Chest pain, discomfort, or pressure		25. Swollen Joint, Joint Injury, or Dislocation	
8. Tuberculosis		26. Sprain, Muscle or Ligament Tear, Tendonitis	
9. Marfan Syndrome		27. Severe muscle cramps	
10. Rheumatism or Arthritis		28. Neck or Spine disorder or instability	
11. Sickle Cell Disease or trait (in self or family member)		29. Spitting or Coughing of Blood	
12. Kidney, Lung, Testicle or Eye removed		30. Surgery or Hospitalization	
13. Kidney Disease, Single or Horseshoe kidney		31. Substance Abuse	
14. Concussion or Unconsciousness		32. Communicable Disease	
15. Mononucleosis		33. Fracture or Stress Fracture	
16. Allergies		34. Rupture or Hernia	
17. Blurring of Vision or other eye/vision problems		35. Dizziness or Fainting Spells	
18. Wear/ have worn Glasses or Contact lenses		36. Numbness, weakness, or tingling in arms or legs	

Name of Primary Care Physician / Family Doctor: \_\_\_\_\_

If you checked any of the above boxes, please explain fully: \_\_\_\_\_

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 name 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? \_\_\_\_\_

Signature of Fighter: \_\_\_\_\_

**To be Completed by Physician**

**Physical Examination for:** \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Temperature: \_\_\_\_\_ Pulse: \_\_\_\_\_

General appearance: \_\_\_\_\_

HEENT: \_\_\_\_\_

Pupils: Reg \_\_\_\_\_ Round \_\_\_\_\_ Equal \_\_\_\_\_ React Light \_\_\_\_\_ Accom \_\_\_\_\_

OD \_\_\_\_\_ OS \_\_\_\_\_ Periorbital scars \_\_\_\_\_

Acuity \_\_\_\_\_

Oropharynx: \_\_\_\_\_

Neck: LA \_\_\_\_\_ Goiter \_\_\_\_\_ ROM \_\_\_\_\_

Lungs: \_\_\_\_\_

Heart: \_\_\_\_\_

Abd: \_\_\_\_\_

Inguinal region: \_\_\_\_\_

Cervical Spine/Neck: \_\_\_\_\_

Back: \_\_\_\_\_

Shoulders: \_\_\_\_\_

Arm/Elbow/Wrist: \_\_\_\_\_

Knees: \_\_\_\_\_

Ankles: \_\_\_\_\_

Hips: \_\_\_\_\_

Hands/Feet/Small Joints: \_\_\_\_\_

Skin: \_\_\_\_\_

Neuro: \_\_\_\_\_

Gait: \_\_\_\_\_ Romberg: \_\_\_\_\_ FNF: \_\_\_\_\_ RAM: \_\_\_\_\_

Muscle stretch reflexes: \_\_\_\_\_ Motor: \_\_\_\_\_ Sensory: \_\_\_\_\_

Orientation: Self, time, place: \_\_\_\_\_

Mental assessment: \_\_\_\_\_

Contestant is physically and mentally fit to fight in a Combative Martial Arts competition. O Yes O No

Physician's Signature: \_\_\_\_\_ Date of Exam: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Practice/Company (if applicable): \_\_\_\_\_

Physician License Number: \_\_\_\_\_ State of License: \_\_\_\_\_

Street Address: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone :( ) \_\_\_\_\_