World Kickboxing Association

Richmond, Virginia

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Richmond, VA 23294

804-525-4780

(804) 977-6249 (fax)
admin@wkausa.com
www.WKAUSA.com

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.

Physicans' 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: **BLOODWORK IS NOT REQUIRED FOR NATIONALS**

- 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 Professional Physical Examination Report

Front To be Completed by Fighter

Name of Event: 2023 WKA NATIONALS **Date of Event:** AUGUST 25 - 27 2023
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: _____

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 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 covenant 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 free will.

Participant	**Date**	**Parent or Legal Guardian if under 18**	**Date**

Reviewed By	**Date**

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: _____ Rhomberg: _____ FNF: _____ RAM: _____

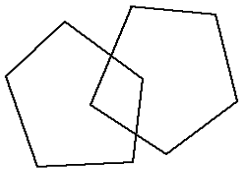
Muscle stretch reflexes: _____ Motor: _____ Sensory: _____

Orientation: Self, time, place: _____

Mental assessment: _____

Physical Examination Continued for: _____

MMSE (required for professional fights)

		Comment	Score	Poss
1.	Year, season, month, date, day			(5)
2.	Where are we? State, county, city, building, floor			(5)
3.	Repeat names of 3 objects (e.g.: ball, apple, cow)			(3)
4.	Serial 7's 100, 93, 86, 79, 72, 65			(5)
5.	Recall: repeat the three objects again			(3)
6.	Name identified objects (e.g.: pen and watch)			(2)
7.	Repeat sentence (e.g.: "No ifs, ands, or buts")			(1)
8.	Follow three-step command (e.g.: take paper in your hand, fold it in half, and put it on the floor.)			(3)
9.	Copy design 			(1)
10.	May comment on reading, writing ability			

A total score of 0-21 suggests cognitive impairment Total score: _____

Other physician observations : _____

_____

_____

Assessment:

Participant may require the following additional testing prior to competition (varies by state)

EKG _____ CT _____
EEG _____ Neuro psych _____
UA _____ MRI _____
Ophtho _____ Other _____
Neuro _____ _____

I have examined the above contestant on (date): _____

☐ This athlete shows no physical findings that would prohibit his/her participation in the listed event.

☐ This athlete should have close follow up for the following conditions, by his/her primary care physician.

☐ This athlete should not compete today.

Comments: _____

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: ( ) _____