



World Kickboxing Association



35 years old and older Physical Examination Report

Front To be Completed by Fighter

Name of Event: WKA US Nationals **Date of Event:** May 22-24, 2020
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.

<hr/>	<hr/>	<hr/>	<hr/>
Participant	Date	Parent or Legal Guardian if under 18	Date
<hr/>	<hr/>		
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: _____ Romberg: _____ FNF: _____ RAM: _____

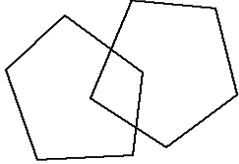
Muscle stretch reflexes: _____ Motor: _____ Sensory: _____

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 : _____

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: () _____