World Kickboxing Association

Comprehensive Physical Examination Report
2016 WKA USA National Championships & US Team Trials
Front To be Completed by Fighter

Name of Event: 2016 WKA USA National Championships **Date of Event:** May 19 - 22, 2016
First Name: ____________________ Last Name: ____________________ DOB: ________ O Male O Female
Street Address: ______________________________ City: ____________________ State: _______ Zip: ________
Country: ______________________ Phone: ( ) ______________________
Email: ____ **** Will receive WKA Fighter License via email**
Do you have a Health Insurance? O yes O 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 (name of competitor): ______________________________

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: _____________

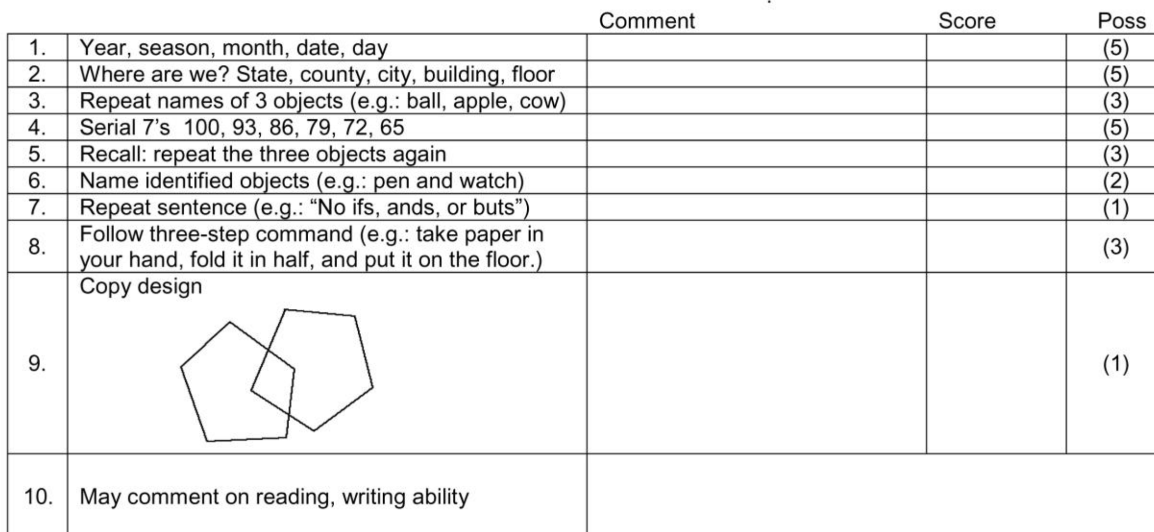
Muscle stretch reflexes: ________________ Motor: _____________ Sensory: _______________

Orientation: Self, time, place: ______________________________

Mental assessment: ______________________________

Physical Examination for (name of competitor): ______________________________

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: ( ) ________________