Richmond, Virginia

8032 W. Broad St. 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:

- 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.



World Kickboxing Association



Comprehensive Professional Physical Examination Report

Front To be Completed by Fighter

Name of Event:			Date of Event:		
First Name:	Last Name:		Date of Event: DOB:	O Male O Fe	male
Street Address:	D . (_ __ City:	Sta	ate:Zip: _	
Email:	Phone: ()	** Will receive		
Do you have a Health Insurance? O yes	O no If so, wit	h what compar	will receive	e WKA Fighter Licens	e via eman
			·,·		
Medical History:					
Have you ever had, or do you currently h	nave any of the			oxes of all that app	oly.
Blood Disorder or Anemia		19. Hepati			
2. Seizure or Convulsions		20. Diabet	es		
3. Rheumatic Fever		+ +	cal Impairment		
Asthma or Shortness of Breath		22. Skin D	Disease or Rash		
5. High Blood Pressure		23. Chroni	c Cough		
6. Heart Disease or Heart Murmur		24. Heada	ches		
7. Chest pain, discomfort, or pressure		25. Swolle	en Joint, Joint Injury, or Disloc	cation	
8. Tuberculosis		26. Sprain	, Muscle or Ligament Tear, T	Γendonitis	
9. Marfan Syndrome		27. Severe	e muscle cramps		
10. Rheumatism or Arthritis		28. Neck o	or Spine disorder or instability	y	
11. Sickle Cell Disease or trait (in self or family m	ember)	29. Spittin	g or Coughing of Blood		
12. Kidney, Lung, Testicle or Eye removed		30. Surgei	ry or Hospitalization		
13. Kidney Disease, Single or Horseshoe kidney		31. Substa	ance Abuse		
14. Concussion or Unconsciousness		32. Comm	nunicable Disease		
15. Mononucleosis		33. Fractu	re or Stress Fracture		
16. Allergies		34. Ruptur	re or Hernia		
17. Blurring of Vision or other eye/vision problem	S	35. Dizzino	ess or Fainting Spells		
18. Wear/ have worn Glasses or Contact lenses		36. Numbi	ness, weakness, or tingling ir	n arms or legs	
		_ <u> </u>			<u> </u>
Name of Primary Care Physician / Famil	y Doctor:				
If also also also also also also also also	alaaaa ayyalaha f				
If you checked any of the above boxes, p	piease explain ti	ully:			
Do you have any other information conce					uestions?
(if yes, describe fully):					
Are you taking any Medications or Drugs	s?	_ Please list ar	nd give the name of the	prescribing doctor	r.
Date of Last Fight: /	/				
Date of Last Fight: / How Many Knock Outs have you suffere Longest duration of unconsciousness Length of time before returning to contact	d? KO	TKO	Date of Las	st KO/	/
Longest duration of unconsciousness		_ (# of min, ho	ur, days)		
Have you ever been knocked unconscio. What is your average non-fight weight?			· [
					4
Signature of Fighter:					1

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

Physica	al Examination for: _					
Height:	Weight:	Blood Pre	essure:	Temperature:	Pulse:	
Genera	al appearance:					
HEENT	T:					
	OD Acuity	Round OS		React Light Periorbital scars	Accom	
Neck:				И		
Skin:						
				RAM:		
Muscle	stretch reflexes:		Motor:	Sensory:		
Orienta	tion: Self, time, place	e:				
	assessment:					

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)
Name identified objects (e.g.: pen and watch)			(2)
7. Repeat sentence (e.g.: "No ifs, ands, or buts")			(1)
Follow throo-stop command (o.g.: take paper in			` ′
8. your hand, fold it in half, and put it on the floor.)			(3)
Copy design			
^			
9.			(1)
\ \ ~			
10. May comment on reading, writing ability			
A total score of 0-21 suggests aganitive impairment		Total score:	
A total score of 0-21 suggests cognitive impairment		TOTAL SCORE.	
Other physician observations :			
other physician observations .			
Assessment: Participant may require the following additional testing price EKG	CT	ies by state)	
EEG	Neuro psych		
JA	MRI		
Dphtho	Other		
Neuro			
have examined the above contestant on (date):			
$\operatorname{\beth}$ This athlete shows no physical findings that would pro	ohibit his/her participa	ation in the listed event.	
$\operatorname{\square}$ This athlete should have close follow up for the follow	ing 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 (it	f applicable):	
Physician License Number	State of License:		
Physician License Number: Street Address:	City	State:	7in·
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Physical Examination Continued for: