



ATHLETE'S NAME: \_\_\_\_\_

**VANCOUVER ATHLETIC COMMISSION**

**MEDICAL EXAMINATION**

**A note to the athletes:** In order to be declared fit to compete, a complete medical assessment along with bloodwork is required. Be respectful to your fellow competitors and others that support your efforts. Ensure that all medical requirements are completed in adequate time prior to the fight. It is recommended that you arrange to complete the medical requirements *at least* 3 weeks prior to the bout. Incomplete medicals will not be accepted. All questions must be answered in full.

***Completed medicals must be received no later than 10 days before the event.***

Please fax the completed form to Dr. M. Brache at 604-913-4364 by \_\_\_\_\_

**PART I – to be completed by contestant:**

Name \_\_\_\_\_ Date of birth 

D	M	Y
___	___	___

Address \_\_\_\_\_

City \_\_\_\_\_ Telephone No: \_\_\_\_\_

Personal Health Number \_\_\_\_\_

Family Physician \_\_\_\_\_ Address: \_\_\_\_\_

Past illnesses / Hospitalizations / Surgeries (give dates) \_\_\_\_\_

Medications you use \_\_\_\_\_ Allergies \_\_\_\_\_

Total number of fights \_\_\_\_\_ Win/loss record \_\_\_/\_\_\_/\_\_\_

Last fight date (d / m / y) \_\_\_/\_\_\_/\_\_\_ Result \_\_\_\_\_

Injuries sustained in last fight \_\_\_\_\_

Did you receive a suspension? (give details) \_\_\_\_\_

Number of times KO'd \_\_\_\_\_ Date you were last ko'd / tko (d/m/y) \_\_\_/\_\_\_/\_\_\_

Date of next fight (d/m/y) \_\_\_\_\_

Do you smoke? \_\_\_\_\_ How much? \_\_\_\_\_

Have you ever been in contact with, been examined by a physician for, or had a blood test for "AIDS" \_\_\_\_\_

Have you ever had a blood transfusion? \_\_\_\_\_ When? \_\_\_\_\_

ATHLETE'S NAME: \_\_\_\_\_

HAVE YOU SUFFERED OR DO YOU NOW SUFFER FROM ANY OF THE FOLLOWING?

	YES	NO
HEADACHES		
SEIZURES / CONVULSIONS		
PSYCHIATRIC PROBLEM / ANXIETY / PANIC ATTACKS		
VISUAL DISTURBANCE or OTHER EYE PROBLEM		
DIZZY SPELLS or BLACKOUTS		
EAR OR HEARING PROBLEM		
SINUS or NASAL TROUBLES		
BLEEDING TENDENCIES		
HIGH BLOOD PRESSURE		
HEART PROBLEM		
ASTHMA or OTHER LUNG PROBLEM		
KIDNEY PROBLEM		
HEPATITIS / JAUNDICE		
INTESTINAL PROBLEM or HERNIA		
SKIN PROBLEM		
DIABETES		
MONONUCLEOSIS		
JOINT DISEASE		
JOINT INJURY or RIB INJURY		
BROKEN BONES		

Details of any "yes" answers above \_\_\_\_\_

\_\_\_\_\_

Do you have any other health problems not covered by the above questions?

\_\_\_\_\_

***"I declare the above answers to be full, complete and true. I confirm that I will inform Dr. Brache of any change in my medical status prior to the weigh-in for the next event. I understand that false information will be grounds for suspension of my fight license indefinitely."***

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_ WITNESSED: \_\_\_\_\_

(See next page re. MEDICAL EXAMINATION **PART II** to be completed by licensed MD)

ATHLETE'S NAME: \_\_\_\_\_

**MEDICAL EXAMINATION PART II  
(to be completed by licensed MD only)**

**To the Physician:** The above named wishes to be examined as to his or her physical fitness to participate in a professional fight event. Your thorough assessment of this athlete is crucial to his/her safety during the event.

- Please witness your patient's signature on Part I and complete all portions of Part II.
- You are kindly requested to pay particular attention to the neurological examination and any evidence of acute injury or illness that may preclude the athlete's participation, as well as areas below marked with an asterisk(\*).
- Bloodwork requirements are detailed on page 4, and are essential.
- Copies of the Lab reports must be provided.

Please call Dr. Brache at 604-512-7179 (c) or 604-443-0756 (pgr) if any questions.

GENERAL APPEARANCE: \_\_\_\_\_ HT: \_\_\_\_\_ WT: \_\_\_\_\_

VITAL SIGNS: BP: \_\_\_\_\_ (repeat if over 140/90) PULSE: \_\_\_\_ RHYTHM: \_\_\_\_\_

VISION: UNCORRECTED: Rt: \_\_\_\_\_ Lt: \_\_\_\_\_ Both: \_\_\_\_\_

	NORMAL	ABNORMAL	COMMENTS
<b>HEAD AND NECK</b> (general)			
*VISUAL FIELDS			
*EXTRAOCULAR MOVMENTS			
*FUNDI			
NECK ROM			
HEARING (whisper test)			
<b>CHEST</b> (general)			
LUNG FIELDS (auscultation)			
HEART SOUNDS			
*MURMURS?			
BREAST EXAM (for female fighters)			
<b>ABDOMEN</b> (general)			
LIVER/SPLEEN			
MASSES?			
*INGUINAL CANALS (hernia)			
GENITALIA			
<b>UPPER EXTREMITIES</b> (joint injury)			
<b>LOWER EXTREMITIES</b> (joint injury)			
<b>SPINE</b> (ROM)			
<b>*NEUROLOGICAL EXAM</b> (general)			
REFLEXES			
PLANTAR RESPONSES			
RHOMBERG TEST RESULT			
FINGER-TO-NOSE TEST			
<b>SKIN</b> (rashes, sores, wounds)			
<b>APPARENT MENTAL STATUS</b>			

ATHLETE'S NAME: \_\_\_\_\_

Is there any evidence of drug or alcohol abuse? \_\_\_\_\_

Any findings on examination not covered on previous page? \_\_\_\_\_

**LABORATORY:**

**URINALYSIS:** PROTEIN: \_\_\_\_\_ GLUCOSE: \_\_\_\_\_ SG: \_\_\_\_\_ BLOOD: \_\_\_\_\_

**PREGNANCY TEST:** for female fighters **within 7 days of event** (may be done at weigh-in if athlete brings pregnancy kit from Pharmacy)

THE FOLLOWING BLOODWORK IS REQUIRED **WITHIN 6 MONTHS OF THE EVENT.**  
COPIES OF LABORATORY REPORTS **MUST** BE PROVIDED:

1. **HEPATITIS B SEROLOGY**

2. **HEPATITIS C SEROLOGY**

3. **HIV SEROLOGY**

4. **CBC**

"I HEREBY CERTIFY THAT I HAVE EXAMINED \_\_\_\_\_  
ON \_\_\_\_\_, 200\_\_\_\_. EACH ITEM ABOVE HAS BEEN CHECKED BY  
MYSELF. THIS FIGHTER IS FIT / IS NOT FIT TO FIGHT IN THE EVENT SCHEDULED FOR  
\_\_\_\_\_, 200\_\_\_\_.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
MSP NO. or MD LISENCE NO.

DOCTOR'S OFFICE STAMP **MUST**  
APPEAR  
IN THIS SPACE OR FORM IS INVALID