ATHLETE'S NAME: ___________________

VANCOUVER ATHLETIC COMMISSION

MEDICAL EXAMINATION

<u>Note to the athletes</u>: In order to be declared fit to compete, a medical assessment and investigations are required. Ensure that all medical requirements are completed in adequate time prior to the fight. Incomplete medicals will not be accepted. All questions must be answered in full.
Completed medicals must be received no later than 30 days before the event.

Please fax the completed form to Dr. ___________ at ___________

PART I – to be completed by ATHLETE:

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 take _______________________________ Allergies____________________

Total number of fights ______ Win/loss/draw 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 (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 "HIV" or "AIDS"?

____

Have you ever had a blood transfusion? ___________ When? ________

. . ./2

ATHLETE'S NAME: ________________

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

	YES	NO
Headaches		
Dizzy spells		
Memory loss or impairment		
Epilepsy / Seizures / Convulsions		
Depression / Anxiety / Panic attack / or psychiatric condition		
Back or spine or spinal cord problem		
Injury or disease of joints, bones, ribs		
Visual disturbance or eye problem		
Ear or hearing problem		
Sinus or nasal problem		
Bleeding tendency		
High blood pressure		
Heart problem		
Asthma or other respiratory problem		
Kidney problem		
Liver problems / Hepatitis / Jaundice		
Digestive / intestinal problem		
Hernia		
Skin problem		
Diabetes		
Mononucleosis		

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 the Medical Director 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 PHYSICIAN 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(*).
- Lab test requirements are detailed on page 4, and are essential.
- Copies of the Lab reports must be provided.

Please call Dr. ___________ at ___________ 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
HEAD AND NECK (general)			
*Visual fields			
*Extraocular movements			
*Fundi			
Neck range of motion			
Hearing / whisper test			
CHEST (general)			
Lung fields			
Heart sounds			
*Murmur?			
Breast exam for female fighters			
ABDOMEN (general)			
Liver / spleen			
Masses?			
*Inguinal areas / hernia check			
Genitalia			
UPPER EXTREMITIES (joint injury)			
LOWER EXTREMITIES (joint injury)			
SPINE			
***NEUROLOGICAL EXAM** (general)			
Orientation (person, place, time)			
Speech (e.g. slurred? delayed?)			
Reflexes			
Plantar responses			
Rhomberg test			
Finger-to-nose test			
Gait			
SKIN (rashes, sores, wounds)			

. . ./2

ATHLETE'S NAME: ___________________

Is there any evidence of drug or alcohol abuse? ____________________________________

Any findings on examination not covered on previous page? __________________________

____

LABORATORY:

Urinaysis: Protein: _____ Glucose: ______ Blood: ______ Specific Gravity: _______

Pregnancy test: for female fighters ***within 7 days of event***

The following lab work must be done ***within 90 days of the event***. Copies of results must be provided:

1. ***Hepatitis B Surface Antigen***
2. ***Hepatitis C serology***
3. ***HIV serology***
4. ***CBC***

Also

5. ***A brain CT or MRI scan conducted once as a baseline measure is required for each fighter. If the fighter has already done a scan, please send the most recent report. A repeat test may be required if asked for by the Medical Director (e.g. if a more recent head injury has occurred or has been suspected to have occurred).***
6. ***Dilated eye exam (indirect fundoscopy)conducted by an optometrist or ophthalmologist is required within 12 months of the event***

"I HEREBY CERTIFY THAT I HAVE EXAMINED ____________________________ (NAME) ON _____________________ (DATE) AND I HAVE COMPLETED THIS EXAM FORM.

THIS FIGHTER IS FIT / IS NOT FIT (CIRCLE ANSWER) TO FIGHT IN THE EVENT SCHEDULED FOR ________________(DATE).

____________________________ SIGNATURE

____________________________ MSP NO. or MD LICENSE NO.

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

Revised April 2011