

ISKA PRE FIGHT MEDICAL ASSESSMENT



Please read the below information and complete ahead of your medical at registration. Any competitor under the age of **18** should have this completed by their parent / legal guardian.

Name			
Club			
Date of Birth			
Address			
Mobile Number			
Date of last fight		Result of Last Fight	Win / Loss / Draw
How much weight have you lost coming up to this fight?			KG
Medical Details			
Do you have any medical problems we need to know about?	Yes	No	
Do you take prescribed medication or any new medication in the last 2 weeks?	Yes	No	
Have you every been knocked out? – if yes please give date ___/___/___	Yes	No	
Has anyone in your immediate family died from heart problems under 40?	Yes	No	
Do you have any injuries which may prevent you from fighting?	Yes	No	
Have you ever had surgery including eye or musculoskeletal?	Yes	No	
Are you taking any vitamins, sports supplements or herbal medication?	Yes	No	
Do you wear any protective equipment when fighting?	Yes	No	
Have you ever been barred or deemed unfit to participate in any competition?	Yes	No	
Have you used any recreational drugs or alcohol in the last 24 hours?	Yes	No	
Do you have any allergies the medical team need to be aware of?	Yes	No	
Is there anything else you feel the medical team should be made aware of?	Yes	No	
Additional Information			

Do you have or have you ever had any of the following?					
Frequent Headaches	Yes	No	Dizziness or fainting	Yes	No
Seizures	Yes	No	Shortness of breath	Yes	No
Asthma	Yes	No	Epileptic Seizures	Yes	No
Ruptured ear drum	Yes	No	Visual disturbance	Yes	No
Lung disease	Yes	No	Hypertension	Yes	No
Detached Retina	Yes	No	Recent Surgery	Yes	No
Chest Pain	Yes	No	Heart murmurs	Yes	No
Concussion	Yes	No	Dislocated joints	Yes	No
Frequent nose bleeds	Yes	No	Thyroid problems	Yes	No
Heart Disease	Yes	No	Blackouts	Yes	No
Kidney/Spleen ailments	Yes	No	Broken Bones	Yes	No
Additional Information					
Disclaimer – Please Read					
I certify that I have read and accurately recorded all information provided above.					
This information is accurate as of todays date:					
I release the promoter and medical team from any responsibility for the assessment or any injury that might result directly or indirectly from participating in a contact sport or any other activity for which this assessment was completed.					
Signed				Print Name	

To be completed by medical team pre competition				
Height CM		BMI		
Weight KG		MSCs x 4	YES	NO
Heart Rate		Blood Pressure		
SpO2		Respiration Rate	/min	
Pupils size L/R		Pupils Reactive?	YES	NO
Additional Information				
Name:		Pin:		