ANNUAL ATHLETE PHYSICAL FORM -WBCMTUSA ATHLETES

The information contained in this medical history form will only be used by WBC Muaythai USA (WBCMTUSA) for purposes of determining if you pose a health threat/risk to yourself in the ring and to review your past medical history in the event of a new emergency or re-occurrence. This information will always remain confidential. Please complete this questionnaire with your physician. Print clearly in BLUE or BLACK ink only.

PERSONAL INFORMATION (SECTION 1)							
LAST NAME:		**FIRST NAME:**		**M.I.**			
D.O.B.		**AGE:**		**GENDER:**		**NATIONALITY:**	
EMAIL:						**PHONE:**	
EMERGENCY CONTACT NAME:						**PHONE:**	
GYM/CLUB:				**TRAINER:**			

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS?								
CONDITION:	**YES**	**NO**	**CONDITION:**	**YES**	**NO**	**CONDITION:**	**YES**	**NO**
BLEEDING OR OTHER BLOOD DISORDER			EPILEPSY/SEIZURE			CATARACTS		
OPEN WOUND/SUTURED CUT			BLURRED VISION			DIABETES		
HIGH TEMPERATURE/PYREXIA			HEARING LOSS			FAINTING		
HEADACHES/MIGRAINES			BALANCE PROBLEMS			DIZZINESS		
HIGH BLOOD PRESSURE			ASTHMA/BRONCHITIS			HERNIA		
ANY HEART CONDITION			RECURRENT NECK PAIN			HIV		
CHEST TRAUMA/RIB FRACTURE			RECURRENT BACK PAIN			HEPATITIS		
CHRONIC OR ACUTE INFECTIOUS DISEASE			MENTAL ILLNESS			PREGNANCY		
RHEUMATIC FEVER			NERVOUS DISORDERS					
RENAL/BLADDER DISEASE			OTHER INJURY/DISEASE					

COMMENTS:……

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WBC MUAY THAI USA

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1) ARE YOU OVER THE AGE OF 40? YES:☐ NO:☐
2) HAVE YOU HAD A FIGHT THAT ENDED IN KO OR TKO IN THE PAST 3 MONTHS? YES:☐ NO:☐
3) HAVE YOU EVER TESTED POSITIVE WITH ANY ANTI-DOPING AGENCY)? YES:☐ NO:☐
4) ARE YOU CURRENTLY TAKING ANY MEDICATION? YES:☐ NO:☐

*IF YES, PLEASE LIST & ENSURE THAT YOU HAVE SUBMITTED A THERAPEUTIC USE EXEMPTION (TUE) FORM

5) HAVE YOU HAD ANY TYPE OF SURGERY IN THE PAST 6 MONTHS? YES:☐ NO:☐
6) HAVE YOU NEEDED IN-PATIENT TREATMENT IN A HOSPITAL IN THE LAST 6 MONTHS? YES:☐ NO:☐
7) HAVE YOU RECEIVED TREATMENT FOR A BONE FRACTURE, FISSURE OR DISLOCATION IN THE LAST 6 MONTHS? YES:☐ NO:☐
8) DO YOU NORMALLY WEAR EYEGLASSES OR CONTACT LENSES? YES:☐ NO:☐
9) HAVE YOU EVER HAD BACK OR SPINAL SURGERY? YES:☐ NO:☐

COMMENTS:……

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PLEASE BE AWARE IF YOU ARE 16 YEARS AND OLDER,

LABORATORY BLOOD TESTS RESULTS for HIV antibody & HBV (Hepatitis B Surface Antigen) & HCV (Hepatitis C Antibody) must be submitted with this form on the letterhead of the laboratory or physician that administered the tests. The blood tests must be taken within 6 months prior to the date of competition.

MEDICAL HISTORY STATEMENT: I have completed this medical history questionnaire and answered it truthfully and to the best of my knowledge. I am prepared to answer questions from WBCMTUSA (including athletic trainers, nurses, consultants, coaches, and coordinators) and general practitioners concerning this medical history and medical conditions. I affirm also that I do not suffer from any disability, injury, condition, or complaint that I have not disclosed on this form. I further recognize the importance of fully and accurately disclosing my physical conditions, past and present, to MTA.

ATHLETE SIGNATURE ……**DATE** ……. / ……. / ……..……

Name of Parent/Guardian: ……

PARENT/GUARDIAN SIGNATURE……**DATE** ……. / ……. / ……..……
(*To be signed by parent/guardian if the participant is under 18 years of age.)

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ATHLETE:		(SECTION 2: PHYSICIANS APPROVAL)	
LAST NAME:		**FIRST NAME:**	

EXAMINATION COMPARISON:							MARK N = NORMAL / A = ABNORMAL
HEAD		EYES		HEART		HEARING	
VISUAL FIELDS		FACE		GUMS		LUNGS	
UPPER EXTREMITIES		FEET		ABDOMEN		SPINE	
LOWER EXTREMITIES		NERVOUS SYSTEM		FRAME	LARGE / MEDIUM / SMALL		
BLOOD PRESSURE							

COMMENTS:……

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Is there any evidence of a change in character, memory, attention span, intelligence, or a tendency to violence outside the competitive area? ……

MEDICAL DOCTOR EXAMINATION & APPROVAL: The applicant's medical fitness for the contact ring sport of Muaythai has been evaluated by physical examination and, if required (at the discretion of the attending physician) using radiology and laboratory facilities. The athlete medical declaration has been reviewed with the athlete and I concur.

To be filled in by physician. Please record the athlete's weight with your comments of whether the athlete is at a healthy weight and hydration for the medical. *Please be aware that this weight will be the marker for the athlete's weight category for the season (12 months) with maximum allowance of +/- 10%.

TO BE FILLED BY PHYSICIAN ONLY:	
Weight (kg.): At medical	
Maximum weight for competition. (for 12 months) +10%	
Minimum weight for competition. (for 12 months) 10%	

This is to certify that …… (athletes first & last name) is in good physical condition and not suffering from any injury, infection, or disability liable to affect his/her capacity to box in the competitions of the full contact sport of Muaythai.

PHYSICIAN SIGNATURE …… **DATE**…… / …… / ……

CLINIC NAME /ADDRESS or CLINIC STAMP: ……

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PHONE: …… **EMAIL:** ……

****IMPORTANT NOTICE TO ATHLETE/GUARDIAN/COACH****

WBCMTUSA acknowledges that weight cutting by means of dehydration, loss of water and minerals from the body may pose a dangerous and life-threatening result, even in amateur sports and young athletes. At MTA we support weight control by fat loss, NOT BY water loss. We therefore urge all athletes, entourage, and stakeholders to take responsibility in this process for the health of the athletes

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ATHLETE :		(SECTION 3: FEMALE NON-PREGNANCY DECLERATION)	
LAST NAME:		FIRST NAME:	

DECLARATION OF NON PREGANCY

(*THIS SECTION IS TO BE COMPLETED BY ALL FEMALE ATHLETES ONLY)

1. DECLARATION OF NON-PREGNANCY FOR FEMALE ATHLETES AGED 18 (EIGHTEEN) AND OVER

NAME OF EVENT ……… ……..…… / ……..…… / ……..……..

EVENT DATE

LOCATION OF EVENT………

I, …… declare that I am not pregnant.

(first & last name)

I understand the seriousness of this statement and accept full responsibility for it. In the event that this declaration is subsequently shown to be inaccurate or false and I suffer from any related injury or damage during the Event, I on behalf of my heirs, executors and administrators, waive and release any and all claims for damages I may have against MTA (including its officials and employees), the organizers of the Event (including the Local Organizing Committee and/or the Host Federation) and the Competitions Venue owners for such injury or damage.

ATHLETE SIGNATURE ……**DATE** ……..…… / ……..…… / ……...

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2. DECLARATION OF NON-PREGNANCY FOR FEMALE ATHLETES AGED UNDER 18 (EIGHTEEN)

LOCATION OF EVENT………

I, …… am one of the parents/legal caretaker of

(first & last name)

…… (insert name of athlete) and declare, on her behalf that she is not pregnant. I understand the seriousness of this statement and accept full responsibility for it in the event that this declaration is subsequently shown to be inaccurate or false and ……(insert name of athlete) suffers any related injury or damage during the Event, I on behalf of ……..(insert name of athlete), her heirs, executors and administrators, waive and release any and all claims for damages she may have against WBCMTAUSA (including its officials and employees), the organizers of the Event (including the Local Organizing Committee and/or the Host Federation) and the Competitions Venue owners for such injury or damage.

PARENT/GUARDIAN SIGNATURE ……**DATE** ……..…… / ……..…… / ……..……

WBC MUAY THAI USA