

# ISKA ARIZONA

## PHYSICAL EXAM PHYSICAL EXAMINATION FOR UNARMED COMBATANT

Applicant Phone: ( ) -

### APPLICANT INFORMATION

MALE  FEMALE

Applicant Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### PHYSICAL HISTORY

Has applicant had any of the following conditions:

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Fainting spells     | <input type="checkbox"/> Rupture (hernia)                                | <input type="checkbox"/> Chest pain    | <input type="checkbox"/> Operations        |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Swollen joints                                  | <input type="checkbox"/> Rheumatism    | <input type="checkbox"/> Diabetes          |
| <input type="checkbox"/> Frequent head aches | <input type="checkbox"/> Convulsions (fits)                              | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Bleeding disorder |
| <input type="checkbox"/> Spitting blood      | <input type="checkbox"/> Cerebral hemorrhage or any other serious injury |  |  |

Number of knockouts received \_\_\_\_\_ Date of last knockout \_\_\_\_\_

Longest duration of unconsciousness \_\_\_\_\_

Have you ever been knocked unconscious in any other sport or in any other way?  Yes  No

If yes, explain: \_\_\_\_\_

### KICKBOXING / UNARMED COMBAT RECORD

Amateur Boxing	Wins _____	Losses _____	Draws _____
Amateur MMA	Wins _____	Losses _____	Draws _____
Amateur Kickboxing / Muay Thai	Wins _____	Losses _____	Draws _____

### PHYSICAL EXAMINATION

General appearance \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Temperature \_\_\_\_\_  
Disabling scars \_\_\_\_\_ Mouth \_\_\_\_\_ Teeth \_\_\_\_\_ Tonsils \_\_\_\_\_ Neck \_\_\_\_\_  
Pulse at rest \_\_\_\_\_ Blood pressure at rest \_\_\_\_\_  
Pulse after 100 hops \_\_\_\_\_ Blood pressure after 100 hops \_\_\_\_\_  
Blood pressure 2 minutes later \_\_\_\_\_  
Enlarged glands  Yes  No Goiter  Yes  No  
Heart: Pulse rhythm  Regular  Irregular Apical impulse  Heavy  Normal  
Enlargement  Yes  No Murmurs  Yes  No  
Lungs: Rales  Yes  No  
Breasts: Mass  Yes  No Tenderness  Yes  No Discharge  Yes  No  
Abdomen: Enlargement of liver  Yes  No Enlargement of spleen  Yes  No  
Hernia  Yes  No Enlargement of spleen  Yes  No  
Testicles: Normal  Yes  No Remarks: \_\_\_\_\_  
Pelvic: Normal  Yes  No Remarks: \_\_\_\_\_  
Reflexes: Pupils \_\_\_\_\_ Knee jerks \_\_\_\_\_ Romberg \_\_\_\_\_ Babinski \_\_\_\_\_  
Skin: Rash \_\_\_\_\_ Boils \_\_\_\_\_ Any other unhealed wounds: \_\_\_\_\_  
Speech: Slurred?  Yes  No Other: \_\_\_\_\_  
General issues (memory, judgment): \_\_\_\_\_  
Remarks: \_\_\_\_\_

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**SEROLOGY**

THE ORIGINAL REQUIRED LAB REPORT WITH APPLICANT'S NAME AND DATE THE TEST WAS PERFORMED MUST BE SUBMITTED.

REQUIRED LAB REPORTS TO INCLUDE: HIV, Hepatitis B (Surface Antigen) and Hepatitis C (Antibody)

**EXAMINING PHYSICIAN (MUST BE AN MD OR DO PHYSICIAN)**

I have examined the above named subject and I  HAVE  HAVE NOT medically cleared to fight.

Remarks: \_\_\_\_\_  
\_\_\_\_\_

PHYSICIAN'S NAME / LICENSE # (PLEASE PRINT) SIGNATURE BY (MD or DO) ONLY DATE

OFFICE NAME

STREET ADDRESS

I AUTHORIZED any physician to release to the International Sport Kickboxing Association (ISKA) any medical record in his/her possession. I also authorize the International Sport Kickboxing Association (ISKA) to release any medical information or other personal information with respect to my status and licensure as an unarmed combatant which may be contained in any of its records to other approved sanctioning organizations or state commissions. I agree that a photographic copy of this authorization shall be valid as the original. I agree that this authorization will be valid for a period of one year from the date indicated in this document

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NAME OF APPLICANT (PLEASE PRINT) APPLICANT'S SIGNATURE DATE

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