KANSAS ATHLETIC COMMISSION

Department of Commerce
1000 SW Jackson, Suite 100
Topeka, KS 66612-1214
Phone: (785)296-0596
Fax: (785) 296-6809

ATHLETIC PARTICIPATION PHYSICAL EXAMINATION FORM

Today's Date: ______________________ **Date of Last Physical:** _________________________

Contestant's Name:___________________________________ Sex: M F (circle one) Age: ______

Date of Birth:___________________________Sport:_______________________ Home Phone: ____________________________

Physician: _______________________________ Phone: __________________________ Fax: _____________________

EMERGENCY CONTACT INFORMATION

Name:____________________________ Relationship to Contestant: _____________________

Phone (work): _____________________ Phone (home): ______________________________ Phone (cell): _________________

Part A: HEALTH HISTORY QUESTIONNAIRE

1. Have you had, or do you currently have:
   a. A sports physical within the past 365 days? Y / N / Don't Know
   b. An injury or illness (in or out of competition) since your last exam? Y / N / Don't Know
   c. A chronic or ongoing illness (such as diabetes, hypertension, asthma, ADHD etc.)? Y / N / Don't Know
   d. Surgery, hospitalization or any emergency room visit(s)? Y / N / Don't Know
   f. Any allergies to medications? Y / N / Don't Know
   g. Any anemias or blood disorders? Y / N / Don't Know

2. Have you had, or do you currently have any of the following *head-related* conditions since your last physical:
   a. Concussion requiring a physician's evaluation? Y / N / Don't Know
      1. How often and when? (Answer below.)
   b. Serious head injuries or cerebral hemorrhage? Y / N / Don't Know
   c. Seizures? Chronic Headaches? Y / N / Don't Know

3. Have you had or do you curently have any of the following *heart-related* conditions since your last physical:
   a. Chest pain? Shortness of Breath? Y / N / Don't Know
   b. Heart murmurs? Marfan Syndrome? Y / N / Don't Know
   c. High blood pressure or elevated cholesterol level? Y / N / Don't Know
   d. Family history of heart problems before the age of 40? Y / N / Don't Know

4. Have you had, or do you currently have any of the following *eye, ear, nose, mouth or throat conditions* since your last physical:
   a. Vision problems? Vision loss? Glaucoma? Dislocated lens Y / N / Don't Know
   b. Eye surgery? Retinal detachment? Y / N / Don't Know
   c. Nasal fractures or frequent nose bleeds? Y / N / Don't Know

5. Have you had, or do you currently have any of the following *neuromuscular/orthopedic conditions* since your last physical:
   a. A burner, stinger or pinched nerve? Y / N / Don't Know
   b. Fractures or stress fractures Y / N / Don't Know
   c. Strains, sprains or dislocations? Y / N / Don't Know
   d. Chronic physical limitations or injuries? Y / N / Don't Know

6. Have you had, or do you currently have any of the following *general or exercise related conditions* since your last physical:
   a. Asthma or exercise induced bronchi spasm Y / N / Don't Know
   b. Present or previous use of inhalers Y / N / Don't Know
   c. History of blackouts, fainting or dizziness Y / N / Don't Know
   e. Dermatitis, ringworm, herpes? Y / N / Don't Know
   f. Heat exhaustion or heat stroke? Y / N / Don't Know
   g. How much weight did you lose leading up to this fight? ________________________

7. Females only:

Result of pregnancy test: Positive_______Negative_______

Explain all (yes) answers here (include relevant dates):

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Part B: Physical Examination

Height: __________ Weight: __________ Blood Pressure:_______/_______ Pulse:______bpm.

Vision: R 20/_____L 20/_____Corrected: Y / N Contacts: Y / NGlasses: Y / N

Indicators	Normal? (Circle One)		Abnormal Findings/Comments
Eyes/Fundi/Pupils/Visual Field	YES	NO	
TMJ/Jaw/Mouth	YES	NO	
Teeth/Arulsions/Fractures	YES	NO	
Nose/Septum/Obstruction	YES	NO	
Thyromegaly/Adenopathy	YES	NO	
Chest: Heart/Rythm/Murmurs	YES	NO	
Ribs	YES	NO	
Lungs : Auscultation/Percussion	YES	NO	
Wheeziness/Airflow	YES	NO	
Abdomen: Liver/Spleen	YES	NO	
Tenderness/Masses:	YES	NO	
Genitalia: Hernia/Testes	YES	NO	
Skin: Rashes/Lesions	YES	NO	
Neck/Back/Spine Range of Motion/Scoliosis	YES	NO	
Upper Extremity: Hands/Wrist:	YES	NO	
Elbows/Shoulders	YES	NO	
Lower Extremity: Hips/Knees	YES	NO	
Ankles/Feet	YES	NO	
Neurological: Balance & Coordination:	YES	NO	
Female Contestants: Breast Mass/Tenderness	YES	NO	
Medications currently being used:			

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Additional Observations:

I hereby certify that I have examined the named individual and in my opinion, this **individual is** ☐ **or is not** ☐ medically fit to participate as a contestant in a professional boxing, kick boxing, martial arts contest or wrestling. I also attest that I do not have a professional relationship with, nor financial interest in the earnings of this individual.	
MUST BE COMPLETED AND SIGNED BY M.D. OR D.O.	
PRINT NAME OF EXMAINING PHYSICIAN	PHYSICIAN'S LICENSE NUMBER
SIGNATURE OF EXAMINING PHYSICIAN	ADDRESS OF PHYSICIAN
TELEPHONE NUMBER OF PHYSICIAN	

I hereby authorize the Kansas Athletic Commission to release, disclose and furnish to any other boxing or athletic commission affiliated with the Association of Boxing Commissions, (ABC), any and all of my medical records concerning my licensure as a participant including, but not limited to, all required medical examinations, laboratory test results for the HIV, hepatitis virus and drug screening, hospital records and any other information regarding conditions related to the propriety of my licensure as a participant (including history, findings, diagnosis or prognosis).
I understand, and it is agreed, that the signing of the Medical Information Release is optional, and that my declining to sign this document will not result in any adverse action being taken against me by the Kansas Athletic Commission based on my decision.
I understand, and it is agreed, that the medical records described herein will not be released for any purpose other than for a member commission affiliated with the ABC to determine my eligibility to participate in a professional boxing, kick boxing, martial arts or wrestling match. I understand, and it is agreed, that this authorization shall remain in effect to meet the requirements of the Kansas Athletic Commission.
By signing below, I hereby authorize the release of my medical information

PRINT NAME	SIGNATURE OF CONTESTANT	DATE

Part C: Yearly Physical Examination

CARDIOVASCULAR	
Blood Pressure (supine) ___________	(upright) ___________
Blood Pressure after 100 hops ___________	Blood Pressure 2 minutes later ___________
Heart Rate (supine)	(after 2 minutes of exercise)

NEUROLOGIC					
Mental Status:	Orientation____________________/3				
	5-minute recall____________________/3				
Cranial Nerves:	☐ Normal	☐ Abnormal	Strength:	☐ Normal	☐ Abnormal
Tone:	☐ Normal	☐ Abnormal	Gait:	☐ Normal	☐ Abnormal
Coordination:					
Finger to Nose:	☐ Normal	☐ Abnormal	Tandem Gait:	☐ Normal	☐ Abnormal