Combat Sports Competitor Exam Requirements.

All Original Copies with any attachments (Blood Work, EKG) will be required to become licensed in the State of New Hampshire.

Physical & Neurological Examination Form

To be filled out by Primary Care Physician or Health care Provider

Participants Name:_____ D.O.B ____/____/_____

Address: _____ City_____ State____ Zip_____

Height: _____ Weight: _____ Competing Weight Class: _____

Contestant's Medical History: (Has the applicant ever had any of the following conditions)

☐ Fainting Spells	☐ Rupture	☐ Chest Pains	☐ Diabetes	☐ Operations
☐ Shortness of Breath	☐ Swollen Joints	☐ Chronic Cough	☐ Rheumatism	☐ Convulsions
☐ Bleeding Disorder	☐ Freq.Headaches	☐ Spitting Blood	☐ Cerebral Hemorrhage or any other head injury	

PHYSICAL EXAMINATION

Resting Pulse_____ Resting B.P_____

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
	Hernia	☐ Yes	☐ No
Testicles:	Normal	☐ Yes	☐ No

Reflexes: Pupils_____ Knee Jerks _____Romberg _____ Babinski_____

Remarks for specified medical clearances:

_____

_____

_____

_____

NEUROLOGICAL EVALUATION:

Years of combat sports experience _____ Last Fight _____/_____/_____

Have you ever suffered a concussion Yes No Date of incident:_____/_____/_____

Remarks: _____

Have you ever been knocked unconscious Yes No Date of incident:____/_____/_____

Remarks: _____

Mental Status Exam:	Normal	Abnormal
Cranial Nerves:	Normal	Abnormal
Motor Exam	Normal	Abnormal
DTR Exam	Normal	Abnormal
Cerebellar:	Normal	Abnormal
Sensory Exam:	Normal	Abnormal
Gait Exam:	Normal	Abnormal

Comments:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Physicians Signature Date of Exam

Blood Examination Form

To be filled out by Primary Care Physician or Health care Provider

All combat competitors are required to have the following tests performed.

Results are good for 6 months!

____Negative HIV Test

____Negative Hep. B Test

____ Negative Hep C Test

<u>Original copies of the above mentioned test results MUST accompany this application.</u>

Physician.

I acknowledge the New Hampshire Boxing and Wresting Commissions request for negative HIV, HEP B & C tests to compete in combat sports in the state of New Hampshire. I have advised the applicant of this and made them aware of the requirement.

Physician Signature Date

Medications: 1. _____ 2._____

3. _____ 4._____

Applicant Complaints:

_____

_____

_____

_____

_____

EKG PRINTOUT *MUST* ACCOMPANY THIS PHYSICAL EXAM FORM

EKG: ☐ Normal ☐ Irregular

Physician EKG Comments:

_____

_____

_____

_____

Examining Physician: Physician **MUST** check one of the boxes below:

Please check one: I Have ☐ I Have Not ☐ Medically Cleared this fighter for competition

Licensed Physician Name and License Number | Physicians Signature | Date

APPLICANT

I declare under penalty under the laws of the State of New Hampshire that the foregoing information is true and correct; further I realize that any international misrepresentations may result in disciplinary action against my license.

I hereby AUTHORIZE the New Hampshire Boxing and Wrestling Commission (NHBWC)and/or any physician to RELEASE any and all medical information and/or personal information with respect to my status and licensure as a participating athlete which may contain any of the commission's records.

I further authorize the New Hampshire Boxing and Wrestling Commission to RELEASE this information to any person whom the commission determines has a need to know information regarding my personal records on combative licensure. I AGREE that I will fully cooperate with the NHBWC in making my medical history available including but not limited to giving oral or written reports to the NHBWC regarding my medical condition, care and/or treatment.

I further RELEASE,PROMISE TO HOLD HARMLESS, AND CONVENANT NOT TO SUE the NHBWC or any representative of the NHBWC on the basis of its attempts to obtain any of the foregoing information, and I further RELEASE, PROMISE TO HOLD HARMLESS,AND COVENANT NOT TO SUE any persons, firms, institutions or agencies providing such information to representatives of the NHBWC on the basis of its disclosures. I have signed this release voluntarily and of my own free will.

Applicant Signature | Date

Ophthalmological Eye Examination Form

To be filled out by an ophthalmologist or optometrist

Participants Name:_____ D.O.B ____/____/_____

Address: _____ City_____ State____ Zip_____

Date of Exam: _____/_____/_____

History: (Has the applicant ever had any of the following conditions)

Blurred vision Yes No

Surgical Procedures done to either of their eyes or the tissue around the eyes other than simple sutures of the skin around the eyes

Yes No If Yes explain: _____

Has the applicant ever been informed by any physician that they had significant eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphasia, pseudo phakia, dislocated lens, or cataract. Yes No

If Yes, Explain: _____

Eye Disease: Yes No

List Nature of Disease: _____

Eye Injury Yes No

List Nature of Injury: _____

Detached retina surgery on either eye: Yes No

List which eye and where and when the surgery was performed: _____

Examination:

VISION:	Without	With Correction
Right	_____	_____
Left	_____	_____

REFRACTION: If either eye is 20/40 or worse

Right_____ SPH_____ CYL x_____ Acuity _____

Left _____ SPH_____ CYL x_____ Acuity _____

REMARKS:

_____

_____

INTRAOCCULAR TENSION: Right _____mmHG

Left _____mmHG

MOTILITY Normal Abnormal

BINOCULAR VISION Normal Abnormal

SLIT LAMP EXAM	NORMAL		ABNORMAL		SPECIFY ABNORMALITIES
	Left	Right	Left	Right	
Conjuctive Cornea					
Iris/Pupil					
Lens					
Eyelids					

Indirect Ophthalmoscopy (Dilated pupil)

With Scleral Depression	NORMAL		ABNORMAL		SPECIFY ABNORMALITIES
	Left	Right	Left	Right	
Disc					
Mascula					
Vessels					
Peripheral Retina					

Physicians Remarks:

_____
_____
_____
_____

Physician:

I have verified applicants Identification and I have read the above criteria and in accordance with the vision requirements as stated therein, have examined the applicant and I ☐ DO NOT FIND ☐ DO FIND a condition that would preclude them from being licensed to participate in combat sports competitions.

Licensed Physicians name (Print) Signature Date Physicians License Number