



PRE-BOUT PHYSICAL EXAMINATION – Page 1 of 4

Part 1 – To be completed by the Athlete, or parent/legal guardian if under legal age

Name (Last, First, Middle) _____ / /

Date of Birth

Address _____ City _____ Province _____ Postal Code _____

Name, Location and Date of Event _____ Division _____

Name of Physician _____ City/Province _____ Emergency Contact Person/Number _____

Medical History: Have you ever had, or do you currently have any of the following? **(Check all that Apply)**

Please Expand/Explain:

| | | | |
|---------------------------------|---|--|--|
| Bleeding Disorder | Chronic Cough | | |
| Seizure or Convulsions | Headaches | | |
| Persistent Undiagnosed Pain | Swollen Joints | | |
| Asthma or Shortness of Breath | Joint Injury or Dislocation | | |
| High Blood Pressure | Fractures | | |
| Heart Disease | Dizziness or Fainting | | |
| Blood Disorders (Sickle Cell) | Rupture of organ or Hernia | | |
| Loss of one of a paired organs | Osteo or Rheumatoid Arthritis | | |
| Kidney Disease/Horseshoe Kidney | Communicable Disease (HIV, Mononucleosis, Hepatitis etc.) | | |
| Mononucleosis/Hepatitis | Substance Abuse | | |
| Blurred Vision | | | |
| Allergies | | | |
| Glasses/Contacts | | | |
| Diabetes | | | |
| Skin Disease or Rash | | | |

Do you have any other information concerning your health, past or present which is not covered by the above questions? (If yes, describe fully) _____

Female Athletes: Are You Pregnant Y N _____ Last Menstruation: _____
 Are you taking any medications? (Please List) _____



PRE-BOUT PHYSICAL EXAMINATION – Page 2 of 4

Weight Loss

Athlete’s Average Non-Fight Weight: _____

Weight Loss/Gain within the last week (Lbs): _____

Athlete’s Fight History

Date of Last Fight: _____

Have you received a concussion in kickboxing or any other Sport or Activity? Y/N

(Expand) _____

How many of the Following have you sustained? KO ____ RSC (INJURY) ____ When: _____

When were you cleared by a physician to participate (following your last concussion): _____

Name of Physician: _____

Have your ever been suspended by CASK/CSC because of an injury? _____

Were you cleared by a physician to participate Y/N When: _____

Applicant

I declare that all the above mentioned information is true and that I have not intentionally misrepresented any facts about my past or current medical history. I understand that the history, and Pre-Event Physical is provided as screening tool for my safety. It does not replace annual and regular examinations by a primary care physician or family physician. I certify “I have been cleared for kickboxing sport activity by my regular physician.” I authorize Combative Sports Canada/ The Council of Amateur Sport Kickboxing Incorporated and/or its representatives (which include, but are not limited to Ringside physicians and/or Provincial Affiliated) to photocopy this record and maintain it on file.

I release all of my medical records, by all of my treating physicians and hospitals, which may include; medical history, findings, diagnoses, diagnostic test results and prognoses.

I further release, promise to hold harmless, and covenant not to sue the ringside physicians, and/or agents, institutions or firms providing the information which I have released. I sign this waiver voluntarily and of my own free will.

Participant

_____/_____/_____
Date

Parent or Legal Guardian (If under 18)

_____/_____/_____
Date



PRE-BOUT PHYSICAL EXAMINATION – Page 3 of 4

Athlete's Name: _____ **Date:** _____

Part 2 – To be completed by the Physician/Medical Staff

The Physical Examination is to be signed by a physician. A check or no entry indicates normal findings.

Areas of Concern from Page 1: _____

General:

Weight: _____ Blood Pressure: _____ Pulse Rate: _____ Respiratory Rate: _____
Temperature: _____ Observable Skin Rashes/Conditions: _____
Athlete's General Appearance: _____
Concerns: _____

Orthopaedics: (Neck/Back/Extremities):

Range of Motion: (Pain or Limitation) Neck _____ Back _____ Extremities _____
(Findings/Concerns): _____

Neurological Examination:

Orientation to Person, Place and Time: _____ Romberg: _____ Pronator Drift: _____
Reflexes (Upper/Lower Extremity) _____ Sensory: _____ Motor _____
Pupils: Observations (Periorbital Scars etc): _____
P.E.A.R.L.A (Pupils Equal and Reactive to Light/Accommodation) _____
Accommodation _____ Tracking _____ Nystagmus _____ Other: _____
Findings/Concerns: _____



PRE-BOUT** PHYSICAL EXAMINATION – Page 4 of 4**

Eyes, Ears, Nose, Throat:
Eyes: (Other than Cranial Nerves) _____
Nose: _____
Throat: _____ Lymph Nodes: _____ Goiter: _____
Concerns: _____

CardioPulmonary:
Heart : _____
Lungs : _____
Comments: _____

Abdominal/Pelvic:
Abnormalities on Palpation: Y N Where: _____
Organomegaly: Y N Where: _____
Inguinal: _____
Comments: _____

Other: _____
Follow Up: _____

I hereby declare this athlete to be: () Fit, () Unfit to participate in this Combative Sports Canada event.

Physician's Name: _____
Physician's Signature: _____

Date: _____ **Location:** _____