WAKO CANADA

Annual Medical for CASK Passport/Sticker

Mail original form and payment to CASK.
Submit to CASK at least 14 days before event. Rush fee applies if received less than 14 days before event.
No applications accepted week of event.

1. Athlete completes Parts 1 and 2.
2. Athlete's doctor completes Part 3.
3. Athlete submits this entire application/medical to club.
4. Club keeps one copy for club file and mails original form *with payment* to the CASK office.
5. If application is approved, CASK mails the passport/sticker to club within 2 weeks of receiving application.

PART 1 ATHLETE INFORMATION To be completed by Athlete or Parent/Guardian

Have you submitted your CASK membership form? Yes ☐ No, it's attached ☐ Are you under 18

Club name:	DOB: dd mm yy	How old are you?
First name:	Last name:	Male ☐ Female ☐
Email:	Phone:	Alt. phone:

Passport details

Are you applying for passport or a sticker? Passport ☐ (attach a labeled passport-size photo) Sticker ☐

What is your age category? Jr. (under yy) ☐ Intermediate (xx-yy) ☐ Sr. (xx-yy) ☐ Veteran (40 or over) ☐

How many CASK bouts have you had, including exhibitions?

How many *non*-CASK bouts have you had (e.g. boxing, mma, ju jitsue, etc.)?

Payment

Passport or sticker	☐ $25
Medical received by CASK office 14+ days prior to the event	☐ $0
Medical received by CASK office 14-7 days prior to the event	☐ $75
Medical received by CASK office the week of the event	Not accepted
Total amount you are paying	$

☐ Cheque / money order payable to CASK	☐ Credit card (VISA/Mastercard only) Cardholder: Card #: Exp date:

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PART 2 MEDICAL HISTORY To be completed by Athlete or Parent/Guardian

	No	Yes, explain
1. Eye or ear impairment, infections or fever		
2. Rheumatic fever, T.B., pleurisy or asthma		
3. Kidney or urine disorder		
4. Problem or condition with a paired organ		
5. Diabetis Mellitus		
6. Indigestion, vomiting, abdominal cramps		
7. Nervous breakdown		
8. Acute infections or communicable disease (e.g. HIV/AIDS)		
9. Musculoskeletal Injuries		
10. Head injury or concussions		
11. Seizures or epilepsy in self		
12. Seizures or epilepsy in family member		
13. Suspensions from boxing/kickboxing for medical reasons		

Signature of Athlete or Parent/Guardian _____ Date _____

PART 3 MEDICAL EXAM To be completed by Physician

Patient name:			DOB: dd mm yy
Weight	Height	Expiration	Inspiration
Vision right eye /20	Vision left eye /20	Color Vision	Field of Vision
Ears (state of T.M.S. and Degree of Deafness)			
Teeth (any braces?)		Hernia or organomegaly	
Abnormality in Chest, Heath, B.P., or C.N.S			
Male: Undescended testis, crptorchidism			
Female: Breast lesions, bleeding, masses, other dysfunction, pain			
Abnormality in menstrual pattern, amenorrhea, lower pelvic pain			

Is this person fit to participate in amateur kickboxing? **Yes**☐ **No**☐(explain) _____

Physician's Signature: _____ **Date:** _____

Office stamp /
Physician name:
Physician address:
Physician phone and fax number: