MEDICAL EXAMINATION FORM

Issued under the *Boxing and Martial Arts Act 2000* and *Boxing and Martial Arts Regulations 2015*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CONTESTANT DETAILS** | | | | | |
| **FULL LEGAL NAME:** |  | | | | |
| **DATE OF BIRTH:** |  | | | | |
| **SEX:** | **FEMALE**  **MALE** | | | | |
| **RESIDENTIAL ADDRESS:** |  | | | | |
| **SUBURB:** |  | **STATE:** |  | **P/CODE:** |  |
| **PHONE NUMBER:** |  | | | | |
| **EMAIL ADDRESS:** |  | | | | |

Pages 1-3 inclusive to be completed by the Contestant

**COMPETITION HISTORY:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **WINS** | **LOSSES** | **DRAWS** |
| **RESULTS** |  |  |  |

|  |  |  |
| --- | --- | --- |
| Have you suffered any injuries while competing?  If yes, please provide details: | Y | N |
| Have you had any headaches, vomiting or problems with speech or vision after a competition?  If yes, please provide details: | Y | N |

**MEDICAL HISTORY:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Y** | **N** | **NOTES:** |
|  | Do you presently have an illness or disability? |  |  |  |
|  | Are you currently receiving medicine, drugs or other treatment? |  |  |  |
|  | Has an accident or illness recently resulted in more than a week off worK? |  |  |  |
|  | Do you  a. drink alcohol  b. smoke |  |  |  |
|  | Have you ever been a patient in any hospital?  Reason |  |  |  |
|  | Do you wear glasses or contact lenses? |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **CONTESTANT DETAILS** | | | |
| **FULL LEGAL NAME:** |  | **DATE OF BIRTH:** |  |

Have you ever had or are you now suffering any of the following:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Y** | **N** | **NOTES:** |
|  | Swollen or painful joints  (other than through injury) |  |  |  |
|  | Shortness of breath |  |  |  |
|  | Pneumonia, bronchitis or pleurisy |  |  |  |
|  | a. Coughing blood  b. Coughing phlegm |  |  |  |
|  | Tuberculosis |  |  |  |
|  | a. Asthma  b. Other lung disease |  |  |  |
|  | a. Deafness  b. Tinnitus (ringing of the ears) |  |  |  |
|  | Any visual problems |  |  |  |
|  | a. Fainting/blackouts  c. Giddiness |  |  |  |
|  | a. Fits or convulsions  b. Epilepsy |  |  |  |
|  | a. Severe headaches  b. Migraines |  |  |  |
|  | a. Nerves/anxiety  b. Severe depression  c. Mental illness  d. Attempted suicide |  |  |  |
|  | a. Kidney disease  b. Bladder disease  c. Pain on passing urine  d. Blood in urine |  |  |  |
|  | Frequent indigestion |  |  |  |
|  | a. Ulcer of stomach  b. Ulcer of duodenum |  |  |  |
|  | a. Gall bladder issues  b. Gall stones |  |  |  |
|  | a. Vomiting blood  b. Passing blood through bowels |  |  |  |
|  | a. Hepatitis or other jaundice  b. Liver disease |  |  |  |
|  | a. Sugar diabetes  b. Gout  c. Cancer  d. Tumour of any type |  |  |  |
|  | a. Rupture  b. Hernia  c. Swollen or painful testicles |  |  |  |
|  | a. Skin sensitivities/issues  b. Tendency to bruise or bleed easily |  |  |  |
|  | a. Concussion  b. Severe head injury  c. Loss of consciousness |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **CONTESTANT DETAILS** | | | |
| **FULL LEGAL NAME:** |  | **DATE OF BIRTH:** |  |

Have you ever had or are you now suffering any of the following:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Y** | **N** | **NOTES:** |
|  | a. Knee injury  b. Ankle injury  c. Back injury  d. Other joint injury or dislocation |  |  |  |
|  | a. Fractured bones  b. Chipped bones |  |  |  |
|  | Paralysis (including polio) |  |  |  |
|  | Have you in the past suffered any other significant illness or disability? |  |  |  |
|  | Are you pregnant? |  |  |  |

|  |  |  |
| --- | --- | --- |
| Do you suffer from any infectious blood borne disease?   * HIV * Hepatitis B * Hepatitis C | Y | N |
| Over the past 5 years, have you either occasionally or regularly, taken any stimulants, sedatives, medications or drugs by mouth or injection? | Y | N |
| If yes, provide details and, if prescribed by a medical practitioner, include the relevant particulars below: |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| Over the past 5 years have you had any medical examination, advice, treatment or been in hospital? | Y | N |
| If yes, provide particulars of each instance (including x-ray, electrocardiogram or other tests) in the schedule below. |  |  |

|  |  |  |
| --- | --- | --- |
| **DATE(S)** | **NAME AND ADDRESS OF DOCTOR AND/OR HOSPITAL** | **REASON** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **CONTESTANT DETAILS** | | | |
| **FULL LEGAL NAME:** |  | **DATE OF BIRTH:** |  |

**ON EXAMINATION:**

If not examined, record NE.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **ABNORMAL** | **NORMAL** | **NOTES:** |
|  | a. Head, face, scalp  b. Neck R.O.M. |  |  |  |
|  | a. Nose deformity  b. Nose airway |  |  |  |
|  | a. Mouth, throat  b. Speech |  |  |  |
|  | a. Teeth, gums  b. Dentures YES / NO |  |  |  |
|  | Ears - general  - hearing |  |  |  |
|  | Tympanic membranes |  |  |  |
|  | Eustachian tubes |  |  |  |
|  | Eyes - general |  |  |  |
|  | Visual fields  Eye Gaze |  |  |  |
|  | Eye movements |  |  |  |
|  | Ophthalmoscopic examination |  |  |  |
|  | Chest, lungs |  |  |  |
|  | Heart (if ECG performed, note result in section 82 & enclose F MED 53) |  |  |  |
|  | Vascular system (include veins) |  |  |  |
|  | Abdomen (include hernial orifices) |  |  |  |
|  | Endocrine system |  |  |  |
|  | External genitalia |  |  |  |
|  | a. Feet  b. Limbs R.O.M.  c. Gait |  |  |  |
|  | a. Spine  b. Trunk R.O.M.  c. Posture (standing) |  |  |  |
|  | Nervous system  Cranial nerves |  |  |  |
|  | a. Cerebellum function  b. Body balance/coordination |  |  |  |
|  | a. Muscle tone  b. Muscle strength  c. Sensation |  |  |  |
|  | Reflexes |  |  |  |
|  | Skin |  |  |  |
|  | Lymphatic system  Lymph glands in neck axilae or inguinal regions |  |  |  |
|  | Emotional stability |  |  |  |
|  | Identifying marks |  |  |  |
|  | Frame  Small Medium Large |  |  |  |
|  | Height (cm) |  |  |  |
|  | Weight (kg) |  |  |  |
|  | Waist (cm) |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **CONTESTANT DETAILS** | | | |
| **FULL LEGAL NAME:** |  | **DATE OF BIRTH:** |  |

**ON EXAMINATION (cont):**

If not examined, record NE.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **ABNORMAL** | **NORMAL** | **NOTES:** |
|  | Urinalysis  Albumin Sugar |  |  |  |
|  | Blood pressure |  |  |  |
|  | Eyes Colour |  |  |  |
|  | Distant vision  R6 Corr 6  L6 to 6  Near vision: Normal / Abnormal |  |  |  |
|  | Particulars of any disabilities |  |  |  |

**NEURO/PSYCHOLOGICAL EXAMINATION:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Y** | **N** | **NOTES:** |
|  | Is there any evidence of a change in character? |  |  |  |
|  | Has he or she a good memory for recent events and, in particular, recent contests? |  |  |  |
|  | Does he or she follow conversation with attention and intelligence? |  |  |  |
|  | Is there any evidence of a tendency to violence outside the competitive arena? |  |  |  |
|  | Is further assessment required? |  |  |  |
|  |  |  |  |  |
| Details of identification presented (e.g. driver’s licence) | | | |  |

As per Section 5(1)(b) of the *Boxing and Martial Arts Regulations 2015*

**MRI SCAN:**

|  |  |  |
| --- | --- | --- |
| Date of MRI Scan: \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_ | | |
| Is the MRI scan results satisfactory? | Y | N |
| Any further testing required? | Y | N |
| If yes, list investigations: |  |  |
|  |  |  |

**SEROLOGY TEST:**

|  |  |  |
| --- | --- | --- |
| Date of Serology tests: \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_ | | |
| Is there evidence that the contestant’s blood is infected with the following viruses? | | |
| HIV (Human Immunodeficiency Virus) | Y | N |
| Hepatitis B antigen (HBsAg) | Y | N |
| Hepatitis C | Y | N |

|  |  |  |  |
| --- | --- | --- | --- |
| **CONTESTANT DETAILS** | | | |
| **FULL LEGAL NAME:** |  | **DATE OF BIRTH:** |  |

|  |  |
| --- | --- |
| **CONTESTANT’S AUTHORISATION** | **MEDICAL PRACTITIONER’S SIGNATURE** |
| I authorise the medical practitioner to:   * provide medical information to the Minister responsible for administering the *Boxing and Martial Arts Act 2000*. * provide medical information to the Office for Recreation, Sport and Racing for the purposes of administering the *Boxing and Martial Arts Act 2000*. * obtain details of my medical records from previous medical attendants. | I have completed the above medical history and examination and have witnessed the contestant’s signature. |
|  |  |
| Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
|  |  |
| Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
|  |  |
| Date: \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_ | Date: \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_ |

**SUMMARY**

I certify that the above individual is **FIT / UNFIT** (select one) to compete in combat sports contests.

|  |  |
| --- | --- |
| Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Medical Practitioner | Medical Practitioner |
|  |  |
| Provider Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_ |

|  |
| --- |
| Medical Practitioner’s Stamp |

CERTIFICATE OF FITNESS

Issued under the *Boxing and Martial Arts Act 2000* and *Boxing and Martial Arts Regulations 2015*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CONTESTANT DETAILS** | | | | | |
| **FULL LEGAL NAME:** |  | | | | |
| **DATE OF BIRTH:** |  | | | | |
| **SEX:** | **FEMALE**  **MALE** | | | | |
| **RESIDENTIAL ADDRESS:** |  | | | | |
| **SUBURB:** |  | **STATE:** |  | **P/CODE:** |  |
| **PHONE NUMBER:** |  | | | | |
| **EMAIL ADDRESS:** |  | | | | |

**REASON FOR MEDICAL EXAMINATION** (select one)**:**

|  |  |
| --- | --- |
| **REGISTRATION** | **ANNUAL MEDICAL** |
| Contestants must have negative HIV, Hepatitis B and Hepatitis C serology results. | Contestants must have negative HIV, Hepatitis B and Hepatitis C serology results. |
| Date of Serology:  \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ | Date of Serology (within the last six months):  \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ |
| Date of MRI Head:  \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ | Date of MRI Head (within the last three years):  \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Please select all the disciplines for which the contestant is registering/registered: | | | | |
| Boxing | Muay Thai | Kickboxing | MMA | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| I certify I have completed the required medical history and examination and witnessed the above person’s signature on page 6 of the Medical Examination Form.  I certify that the above person is **FIT / UNFIT** to compete as a contestant in nominated disciplines. | |
| Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Medical Practitioner | Medical Practitioner |
|  |  |
| Provider Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_ |

|  |
| --- |
| Medical Practitioner’s Stamp: |

REFUSAL TO ISSUE CERTIFICATE OF FITNESS

Issued under the *Boxing and Martial Arts Act 2000* and *Boxing and Martial Arts Regulations 2015*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CONTESTANT DETAILS** | | | | | |
| **FULL LEGAL NAME:** |  | | | | |
| **DATE OF BIRTH:** |  | | | | |
| **SEX:** | **FEMALE**  **MALE** | | | | |
| **RESIDENTIAL ADDRESS:** |  | | | | |
| **SUBURB:** |  | **STATE:** |  | **P/CODE:** |  |
| **PHONE NUMBER:** |  | | | | |
| **EMAIL ADDRESS:** |  | | | | |

**STATE REASON(S) FOR REFUSING TO ISSUE A CERTIFICATE OF FITNESS:**

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

|  |  |
| --- | --- |
| Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Medical Practitioner | Medical Practitioner |
|  |  |
| Provider Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_ |

|  |
| --- |
| Medical Practitioner’s Stamp |