MEDICAL EXAMINATION FORM

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

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| **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 youa. drink alcohol b. smoke |  |  |  |
|  | Have you ever been a patient in any hospital?Reason |  |  |  |
|  | Do you wear glasses or contact lenses? |  |  |  |

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| **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 bloodb. Coughing phlegm |  |  |  |
|  | Tuberculosis |  |  |  |
|  | a. Asthma b. Other lung disease |  |  |  |
|  | a. Deafness b. Tinnitus (ringing of the ears) |  |  |  |
|  | Any visual problems  |  |  |  |
|  | a. Fainting/blackoutsc. Giddiness |  |  |  |
|  | a. Fits or convulsionsb. Epilepsy |  |  |  |
|  | a. Severe headachesb. Migraines |  |  |  |
|  | a. Nerves/anxietyb. Severe depression c. Mental illnessd. Attempted suicide |  |  |  |
|  | a. Kidney diseaseb. Bladder disease c. Pain on passing urined. Blood in urine |  |  |  |
|  | Frequent indigestion |  |  |  |
|  | a. Ulcer of stomachb. Ulcer of duodenum |  |  |  |
|  | a. Gall bladder issuesb. Gall stones |  |  |  |
|  | a. Vomiting bloodb. Passing blood through bowels |  |  |  |
|  | a. Hepatitis or other jaundiceb. Liver disease |  |  |  |
|  | a. Sugar diabetesb. Goutc. Cancerd. Tumour of any type |  |  |  |
|  | a. Ruptureb. Herniac. Swollen or painful testicles |  |  |  |
|  | a. Skin sensitivities/issuesb. Tendency to bruise or bleed easily |  |  |  |
|  | a. Concussionb. Severe head injuryc. Loss of consciousness |  |  |  |

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| **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 injuryb. Ankle injury c. Back injuryd. Other joint injury or dislocation |  |  |  |
|  | a. Fractured bonesb. 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. |  |  |

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| **DATE(S)** | **NAME AND ADDRESS OF DOCTOR AND/OR HOSPITAL** | **REASON** |
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| **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 deformityb. Nose airway |  |  |  |
|  | a. Mouth, throatb. Speech |  |  |  |
|  | a. Teeth, gumsb. Dentures YES / NO |  |  |  |
|  | Ears - general - hearing |  |  |  |
|  | Tympanic membranes |  |  |  |
|  | Eustachian tubes |  |  |  |
|  | Eyes - general |  |  |  |
|  | Visual fieldsEye 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. Feetb. Limbs R.O.M. c. Gait |  |  |  |
|  | a. Spineb. Trunk R.O.M.c. Posture (standing) |  |  |  |
|  | Nervous systemCranial nerves |  |  |  |
|  | a. Cerebellum functionb. Body balance/coordination |  |  |  |
|  | a. Muscle toneb. Muscle strength c. Sensation |  |  |  |
|  | Reflexes |  |  |  |
|  | Skin |  |  |  |
|  | Lymphatic systemLymph glands in neck axilae or inguinal regions |  |  |  |
|  | Emotional stability |  |  |  |
|  | Identifying marks |  |  |  |
|  | FrameSmall Medium Large |  |  |  |
|  | Height (cm) |  |  |  |
|  | Weight (kg) |  |  |  |
|  | Waist (cm) |  |  |  |

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

**ON EXAMINATION (cont):**

If not examined, record NE.

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| --- | --- | --- | --- | --- |
|  |  | **ABNORMAL** | **NORMAL** | **NOTES:** |
|  | UrinalysisAlbumin Sugar |  |  |  |
|  | Blood pressure |  |  |  |
|  | Eyes Colour |  |  |  |
|  | Distant visionR6 Corr 6L6 to 6Near 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 [ ]  |

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

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| **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: \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_ |

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| Medical Practitioner’s Stamp |

CERTIFICATE OF FITNESS

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

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| **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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| 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: \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_ |

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| 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*

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| **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:**

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

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| Medical Practitioner’s Stamp |