Kentucky Boxing and Wrestling Authority
PHYSICAL EXAMINATION FORM
Every section of this form must be completed to be accepted

DATE OF EXAM ____________________________

NAME ____
LAST FIRST MIDDLE
RING NAME ____
CURRENT ADDRESS ____
TELEPHONE No. _____________________________DATE OF BIRTH ________________ AGE ____________ SEX___________

MEDICAL HISTORY (Please complete as thoroughly as possible)

A. Has applicant ever had any of the following conditions:

□ Fainting spells	□ Rupture (hernia)	□ Chest pains	□ Operations
□ Shortness of breath	□ Swollen joints	□ Rheumatism	□ Diabetes
□ Frequent headaches	□ Convulsions (fits)	□ Chronic cough	□ Bleeding Disorder
□ Spitting of blood	□ Cerebral hemorrhage or any other serious head injury		

1. Have you ever been hospitalized? □ YES □ NO, If "YES", give nature of problems(s), date(s), location(s) and attending physicians.
____
____
2. Have you ever had eye surgery? □ YES □ NO Explain ____
3. Have you ever had a retinal detachment? □ YES □ NO. Explain ____
4. Do you regularly or occasionally take any medications or drugs? □ YES □ NO
If "YES" give name(s), frequency and dose ____
____
5. Have you previously been injured in a sporting event? □ YES □ NO If "YES" Describe injuries
____
6. Longest duration of unconsciousness ____
7. How many concussions have you suffered? __________ Date of last concussion ___________________

PHYSICAL EXAM

Height __________ Weight __________ Temperature __________

Does this person have any current or chronic illnesses, physical injuries, abnormalities or physical limitations?
□ YES □ NO

If yes, would these interfere in any manner with this person's ability to participate professional wrestling?
□ YES □ NO

If yes, what limitations should be placed on this person? ____
____

OTOLOGIC	External Trauma	□ YES □ NO	**NOSE**	Instability	□ YES □ NO
	Perforated Drum	□ YES □ NO		Recent Trauma	□ YES □ NO
				Obstruction	□ YES □ NO
ORAPHARYNX	Loose Teeth	□ YES □ NO	**ADENOPATHY**		□ YES □ NO
FACE	Recent Trauma		□ YES □ NO		
	Jaw and Temporomandibular Joints		□ Normal	□ Abnormal	
LUNGS (Rales)	□ Normal □ Abnormal		**TESTES**	□ Normal □ Abnormal	

ABDOMEN

Enlargement of Liver ☐ YES ☐ NO Enlargement of Spleen ☐ YES ☐ NO
Hernia ☐ YES ☐ NO Femoral ☐ Inguinal ☐ Ventral ☐

CARDIOVASCULAR

Blood Pressure (supine) ________________ (upright) ________________
Blood Pressure after 100 hops _____________ Blood Pressure 2 minutes later _____________
Heart Rate (supine) ________________ (after 2 minutes of exercise) ________________

ENLARGE GLANDS ☐ YES ☐ NO **Goiter** ☐ YES ☐ NO

HEART

Pulse Rhythm ☐ Regular ☐ Irregular Apical impulse ☐ Heavy ☐ Normal
Enlargement ☐ YES ☐ NO Murmurs ☐ YES ☐ NO

BREAST (Women Contestants) Mass ☐ YES ☐ NO Tenderness ☐ YES ☐ NO

GYNECOLOGICAL EXAMINATION (Women Contestants): ☐ Normal ☐ Abnormal

MUSCULOSKELETAL:

			Comments
Hands	☐ Normal	☐ Abnormal	______________________
Wrists	☐ Normal	☐ Abnormal	______________________
Elbows	☐ Normal	☐ Abnormal	______________________
Shoulder Girdle	☐ Normal	☐ Abnormal	______________________
Lower Extremities	☐ Normal	☐ Abnormal	______________________

NEUROLOGIC:

Mental Status
Orientation ________________/3
5-Minute recall ________________/3

Cranial Nerves	☐ Normal	☐ Abnormal
Strength	☐ Normal	☐ Abnormal
Tone	☐ Normal	☐ Abnormal
Gait	☐ Normal	☐ Abnormal

Coordination:

Finger to Nose	☐ Normal	☐ Abnormal
Tandem Gait	☐ Normal	☐ Abnormal

COMMENTS OF EXAMINING PHYSICIAN (Please check if the person is or is not medically cleared below)

____
____
____
____

I hereby certify that I have examined the named individual and in my opinion, this **individual ☐ is or ☐ is not** medically fit to participate as a contestant in a contact sport, I also attest that I do not have a professional relationship with, nor financial interest in the earnings of this individual.

____
(PRINT NAME OF EXAMINING PHYSICIAN)

____
(SIGNATURE OF EXAMINING PHYSICIAN)

Office stamp/card affixed here

____
(PHYSICIAN'S LICENSE NUMBER)

____
(ADDRESS OF PHYSICIAN)

____
(TELEPHONE NUMBER OF PHYSICIAN)