NEW JERSEY STATE ATHLETIC CONTROL BOARD - Amateur Mixed Martial Arts Physical Form

(To Be Completed by Physician - physical must be taken within 45 days of each event - NJSACB fax is 609-292-3756)

Contestant Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

I certify that I have examined the above contestant on _____ and have found him/her to be medically cleared to engage in an Amateur Mixed Martial Arts competition on _____.

Physician Name (printed): _____ Physician Signature: _____

Physician Address: _____ City: _____ State: ____ Zip: _____ Phone: _____

CONTESTANT INFORMATION: Date of Birth: ___/___/___

Age: _____ Height: _____ Weight: _____

Blood Pressure: _____ Pulse: _____

Temperature: _____ Blood Type: _____

Allergies: _____

_____

Medications: _____

_____

EYE EXAMINATION:

No retinopathies or cataracts: _____

Wears contact lenses: _____

EXAMINATION:

Ears - Otoscopy: _____

_____

Mouth Pharynx: _____

_____

Adenopathys: _____

_____

Lungs: _____

_____

Heart: _____

_____

Abdominal Palpation: _____

_____

Hernias or Viscoro-megaly: _____

_____

Testis: _____

_____

TENDON REFLEXES:

Knee Jerk: _____

Babinski: _____

Rhomberg: _____

Finger to nose: _____

UPPER EXTREMITIES:

Hands: _____

Wrist: _____

Elbows: _____

Shoulder Girdle: _____

Lower Extremities: _____

Skin (Open or Superlative lesions): _____

_____

Any indications of active renal disease: _____

_____

PHYSICAL HISTORY:

Chest Pains: _____

Fainting Spells: _____

Spitting of Blood: _____

Shortness of Breath: _____

Frequent Headaches: _____

Convulsions: _____

Head Injury: _____

Operations: _____

Diabetes: _____

Unconsciousness from training or competing: _____

_____

Unconsciousness from any other sport or any other reason:

_____

FOR WOMEN:

Pregnancy Test: _____

Breast Exam: _____

Gynecological Exam: _____

COMMENTS: _____

_____

_____