Kentucky Boxing and Wrestling Commission

500 Mero St, 218NC

Frankfort, Ky 40601

Phone: (502) 564-0085

Fax: (502) 696-3938

Email: kbwc@ky.gov

www.kbwc.ky.gov

PHYSICAL REPORT

This form must be signed by a MD or DO. Forms signed by anyone other than a MD or DO will not be accepted.

☐**Boxing** ☐**MMA** ☐**Wrestler** ☐**Referee**

Date of Exam: _____

Name: _____ _____
Last First Middle Date of Birth

Address: _____ City: _____ State: ____ Zip: _____

Phone Number: _____ Age: _____ Sex: _____

I. MEDICAL HISTORY (to be completed by applicant)

A. Have you ever suffered from 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
□ Migraine headaches	□ Spitting of blood	□ Facial fracture	□ Cerebral hemorrhage or head injury

Do you suffer from any type of headache other than migraine? □ YES □ NO If yes, what type? _____

Have you ever had a head or neck injury? □ YES □ NO If yes, explain: _____

_____

Have you ever had a seizure? □ YES □ NO If yes, when? _____

Do you have any allergies? □ YES □ NO If yes, what are they? _____

Have you ever been hospitalized? □ YES □ NO If yes, give nature of problems(s), date(s), location(s) and attending physicians. _____

_____

Have you suffered a concussion? _____ If yes, how many? _____ Date of last concussion _____

Have you previously been injured in a sporting event? □ YES □ NO If yes, Describe injuries: _____

_____

Do you regularly or occasionally take any medications, drugs, or drops? □ YES □ NO
If yes, give name(s), frequency and dose _____

_____

Have you ever suffered from blurred vision? ☐Yes ☐No

Have you ever had surgical procedures done to eye(s) or the tissue around the eye other than simple sutures of the skin?

☐Yes ☐No If yes, please explain: _____

Have you ever experienced eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia, or dislocated lens? ☐Yes ☐No
If yes, please explain: _____

Boxing and MMA Applicants Only:

Number of knockouts received _____ Date of last KO_____

Longest duration of unconsciousness _____

Length of time before resuming boxing after last knockout _____

Have you ever been knocked unconscious for any reason other than boxing or MMA competition? ☐YES ☐NO
If yes, explain _____

Amateur record: _____ Win _____ Losses _____ Draw

Professional record: _____ Win _____ Losses _____ Draw

Have you ever had Rheumatic Fever? If yes, when were you discharged as cured? _____

List any previous “elimination” matches or “tough-man” events you have fought in: _____

Results_____

List any other serious injuries that you have ever had: _____

Have you ever had a fight stopped for any medical reason? If yes, please specify_____

II. PHYSICAL EXAMINATION **Pages 3 & 4 to be completed by a physician**

Height _____ Weight _____ Temperature _____

OTOLOGIC External Trauma □ YES □ NO
Perforated Drum □ YES □ NO

NOSE Instability □ 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 (If Applicable) □ Normal □ Abnormal

ABDOMEN Enlargement of Liver □ YES □ NO
Hernia □ YES □ NO
Enlargement of Spleen □ 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
Enlargement □ YES □ NO
Apical impulse □ Heavy □ Normal
Murmurs □ YES □ NO

BREAST (If Applicable) Mass □ YES □ NO Tenderness □ YES □ NO

GYNECOLOGICAL EXAMINATION (If Applicable): □ 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

Reflexes: Pupils: _____ Knee jerk: _____ Romberg: Positive/Negative Babinski: Positive/Negative

Skin: Rash:_____ Boils: _____ Any other unhealed wounds: _____

Eye Examination: Vision without correction: Right:_____ Left: _____ Vision with correction: Right:_____ Left: _____

Visual fields: Right:_____ Left: _____

Does the applicant 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 unarmed combat?
□ YES □ NO

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

_____

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 MEDICAL PROFESIONAL) (LICENSE NUMBER)

MEDICAL PROFFESIONAL TYPE (CIRCLE ONE): MD DO OTHER

_____ _____
(SIGNATURE OF EXAMINING MEDICAL PROFESIONAL) (ADDRESS)

*** IF MEDICAL PERSONEL PERFORMING EXAMINATION IS NOT A MD OR DO, THIS ***
*** SECTION MUST BE SIGNED ***

_____ _____
(PRINT NAME OF OVERSEEING PHYSICIAN – MD or DO) (PHYSICIAN'S LICENSE NUMBER)

_____ _____
(SIGNATURE OF OVERSEEING PHYSICIAN) (ADDRESS OF PHYSICIAN)

(Office Stamp or Business Card)

_____
(TELEPHONE NUMBER OF PHYSICIAN)

Physicals submitted without the above box checked by the attending physician will be returned for completion and will delay licensure.