IKF FIGHTER PRE-BOUT PHYSICAL FORM

BOUT #: _____

FIRST ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

LAST ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

AGE ☐☐ **Birthday (Mo, Day & Year):** ☐☐ / ☐☐ / ☐☐ **M** ☐ **F** ☐

CORNER: _____

FIGHTER: Please Answer ALL Of The Following Questions Before Your Fighter Physical Check Below.		
CHECK YES or NO At Right To The Following Questions - USE BACK IF NEEDED.	**YES**	**NO**
Do you have medical insurance?	_____	_____
Any chronic medical conditions? (Diabetes, asthma, heart condition etc.)	_____	_____
If chronic medical conditions? Please Explain:		
Ever had any surgery?	_____	_____
If Had Surgery? Please Explain:		
Ever been Hospitalized?	_____	_____
If Hospitalized - Please Explain:		
Ever had a fracture or dislocation? If yes, when? **M:**_____ **D:**_____ **YR:**____	_____	_____
Ever a sprain or strain requiring special equip or braces? If yes, when? ___ **/**___/ ____	_____	_____
Any vision problems?	_____	_____
Do you wear contact lenses?	_____	_____
Ever passed out while exercising? If yes, when? **M:**_____ **D:**_____ **YR:**____	_____	_____
Ever had chest pains while exercising? If yes, when? **M:**___ **D:**____ **YR:**___	_____	_____
Ever felt dizzy while exercising? If yes, when? **M:**_____ **D:**_____ **YR:**____	_____	_____
Ever had wheezing or coughing while exercising? If yes, when? **M:**____ **D:**___ **YR:**___	_____	_____
Ever been told you have high blood pressure?	_____	_____
Ever feel as though your heart is skipping beats or have runs of irregular rhythm?	_____	_____
Ever been told you have a heart murmur?	_____	_____
Any family members die suddenly before the age of 50?	_____	_____
Any congenital defect such as single kidney, undescended testicle, cardiac defect?	_____	_____
Do you have any hernias, groin or abdominal?	_____	_____
Ever had a head injury or concussion? If yes, When? M:____ **D:**___ **YR:**___	_____	_____
Ever been knocked unconscious? If yes, When? M:____ **D:**____ **YR:**___	_____	_____
Ever had a pinched nerve or numbness or tingling in your arms, hands or feet?	_____	_____
Ever had a heat stroke? If yes, when? **M:**_____ **D:**_____ **YR:**____	_____	_____
Do you have any drug allergies? If yes, what:	_____	_____
WOMEN: You may be asked to take a pregnancy test. ARE YOU PREGNANT?	_____	_____

FIGHTER: If while At THIS event, you become injured and refuse Medical care or the Ringside Physician determines you need to be transported by Ambulance to a Hospital, and you Refuse, YOU have RELEASED ALL LIABILITY to YOURSELF and may NOT be covered under the Event Medical Insurance Policy. This RELEASES The IKF, International Kickboxing Federation and ANY and ALL Staff, Officials & Medical Personnel working this event. YOU acknowledge YOU fully understand this by signing below.

Fighters Signature: _____ **Date:** ____/____/_____

IF UNDER 18 - PARENT OR LEGAL GUARDIAN **SIGNS**: _____ **Date:** ____/____/_____

MEDICAL QUESTIONS: Doctor (MD / DO) Only Below This Line

Physical Check	**RESULT**		**Physical Check**	**RESULT**
TIME OF PHYSICAL	_____	_____	Fighters Eyes	_____
Fighters Age	_____	**BOOKED WEIGHT**	Fighters Heart	_____
Fighters Pulse	_____		Fighters Lungs	_____
Fighters Blood Pressure	_____	_____	Fighters Hernia/Abd.	_____
Fighters Hands	_____	**WEIGH-IN WEIGHT**	Physical Look	_____

Doctor Signature: _____ **Print Name:** _____ **Date:** ____/____/_____