

State of Ohio Athletic Commission  
 242 Federal Plaza West Suite 405  
 Youngstown, OH 44503  
 Office: 330-797-2556  
 Fax: 330-797-2559

# Ringside Physicians Report

## PRE-BOUT EXAM

Date of Event: / /		Participant		Location of Event	
		<input type="checkbox"/> Boxer	<input type="checkbox"/> Referee		
		<input type="checkbox"/> MMA	<input type="checkbox"/> Tough Person		
Name:			Age	Weight	Date of last fight: / /
Eyes/Pupils: L 1 2 3 4 5 6 Equal Reactive			R 1 2 3 4 5 6 Accommodation		Abdomen: <input type="checkbox"/> Soft non-tender <input type="checkbox"/> No hepatomegaly <input type="checkbox"/> No splenomegaly
			<input type="checkbox"/> YES <input type="checkbox"/> NO Lasik Eye Surgery (CANNOT COMPETE)		
Blood Pressure: /	Pulse: /bpm	Respiration	Heart Rhythm	Heart Murmurs	Medications being taken:
ENT: NASAL: Instability <input type="checkbox"/> YES <input type="checkbox"/> NO Obstruction <input type="checkbox"/> YES <input type="checkbox"/> NO					EARS: Clear Cone of light <input type="checkbox"/>
Remarks					THROAT: No White or Red patches <input type="checkbox"/>
Extremities			Pregnancy test: Positive <input type="checkbox"/> Negative <input type="checkbox"/>		Preliminary Drug Test: Positive <input type="checkbox"/> Negative <input type="checkbox"/>

I have been training, I'm in good physical condition and not withholding information relative to my physical condition from the examining physician. It is understood that my failure to inform the examining physician of any recent KO losses, recent illness, prescribed medication, any past surgeries, or any physical defects, places me at my own risk, relieves the commission and the state of Ohio of any responsibility and may subject me to disciplinary action by the commission.

Contestant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Medically cleared:

I find the above named contestant or referee in good physical condition and able to compete or officiate on the above date: \_\_\_\_\_

Physician Signature

Date

## POST-BOUT EXAM

Eyes/Pupils: L 1 2 3 4 5 6 Equal Reactive		R 1 2 3 4 5 6 Accommodation		Alert and Oriented: Remarks:	
OUTCOME: WON <input type="checkbox"/> LOST <input type="checkbox"/> DRAW <input type="checkbox"/>			KO TKO DECISION TAP OUT NO DECISION circle one		

SUSPENSION: 30 DAY  60 DAY  90 DAY  120 DAY  Physician suspension: SPECIFY DAYS \_\_\_\_\_

The first day of any suspension will start the day following the scheduled event. During the suspension period the contestant MAY NOT compete in any striking sport events.

MEDICAL EXAM REQUESTED

TYPE OF EXAM REQUESTED: \_\_\_\_\_

If a medical examine is requested the results of such medical examination MUST be performed by a qualified licensed physician, neurologist, or ophthalmologist and sent to the Ohio Athletic Commission prior to you being released to participate in future events.

PHYSICIAN'S REMARKS: \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_

Date: \_\_\_\_\_