Ohio Athletic Commission
242 Federal Plaza West Suite 405
Youngstown, OH 44503
Telephone: (330) 797-2556 Fax: (330) 797-2559

BOXER ☐

PHYSICAL EXAMINATION REPORT

☐ **MALE** ☐ **FEMALE**

MMA ☐

Name | Date of Birth | **Phone Number**

Address (street) | City | State | zip code

CONTESTANT'S MEDICAL HISTORY: Has the applicant ever had any of the following conditons:

☐ Fainting spells ☐ Rupture (hernial) ☐ Chest Pains ☐ Operations ☐ Diabetes
☐ Shortness of breath ☐ Swollen Joints ☐ Chronic cough ☐ Rheumatism ☐ Bleeding Disorder
☐ Frequent Headaches ☐ Spitting Blood ☐ Convulsions (fits) ☐ Cerebral hemorrrhage or any other serious head injury

PHYSICAL EXAMINATION:

Pulse at Rest _____ Blood Pressure at Rest _____

Pulse after 100 hops _____ Blood Pressure after 100 hops _____

Heart: Pulse Rhythm ☐ Regular ☐ Irregular Apical Impulse ☐ Heavy ☐ Normal
Enlargement ☐ Yes ☐ No Murmurs ☐ Yes ☐ No

Lungs: Rales ☐ Yes ☐ No Breasts: Mass ☐ Yes ☐ No Tenderness ☐ Yes ☐ No Discharge ☐ Yes ☐ No

Abdomen: Enlargement of liver ☐ Yes ☐ No
Hernia ☐ Yes ☐ No Remarks: _____

Testicles: Normal ☐ Yes ☐ No Remarks: _____

Reflexes: Pupils _____ Knee jerks _____ Romberg _____ Babinski _____

Remarks for specified medical clearances: _____

EXAMINING PHYSICIAN: Physician MUST check one of the boxes below:

PLEASE CHECK ONE: I HAVE ☐ **I HAVE NOT** ☐ **MEDICALLY CLEARED THIS FIGHTER TO COMPETE**

Licensed Physician's Name and License Number (Please Print) | Physician's Signature | Date

Street Address | City | State | Phone Number

APPLICANT:

*I declare under penalty of perjury under the laws of the state of Ohio that the foregoing information is true and correct; further I realize that any intentional misrepresentation may result in disciplinary action against my license.

*I hereby **AUTHORIZE** the Ohio Athletic Commission and or any physician employed by the Ohio Athletic Commission to **RELEASE** any and all medical information and/or personal information with respect to my status and licensure as a participating athlete which may contain any of the Commission's records.

*I further authorize the Commission to **RELEASE** this information to any person whom the Commission determines has a need to know. I AGREE that I will fully cooperate with the Commission in making my medical history available including but not limited to giving oral or written reports to the Commission regarding my medical condition, care, and/or treatment.

*I further **RELEASE, PROMISE TO HOLD HARMLESS, AND COVENANT NOT TO SUE** the Commission or any representative of the Commission on the basis of its attempts to obtain any of the foregoing information, and I further **RELEASE, PROMISE TO HOLD HARMLESS, AND COVENANT NOT TO SUE** any persons, firms, institutions or agencies providing such information to representatives of the Ohio Athletic Commission on the basis of its disclosures. I have signed the release voluntarily and of my own free will.

Print Name | **Signature** | **Date**