Record and Medical

Name: _____

Full Address: _____

Next of Kin: _____

_____ _____ _____

Gym _____ **Coach** _____

Date of last fight: _____ **Win*** _____ **Lost*** _____ **K.O./Stopped*** _____
(* please tick the result. You must declare if you were K.O / Stopped in your last contest)

	Yes	No
Are you in good health as far as you know?		
Have you suffered at any time from any serious illness, injury, accident or disability?		
If yes state briefly _____		

Have you suffered at any time from any of the following?

Headaches, blackouts or fits?		
Paralysis or any other mental or nervous diseases?		
Have you seen a psychiatrist or taken tranquillisers?		
Visual disturbances e.g. blurring vision, double vision, etc.?		
Do you wear glasses or contact lenses?		
Heart disease, high blood pressure, heart murmurs, varicose veins, rheumatic fever, scarlet fever?		
Asthma, bronchitis, pneumonia, pleurisy, tuberculosis?		
Sinusitis or any breathing difficulty?		
Chronic indigestion, stomach or duodenal ulcers, gall bladder, liver disease, appendicitis, hernia?		
Kidney, bladder problems, diabetes, renal colic?		
Bone or joint problems, e.g. hand injuries, fractures etc.?		
Do you take tablets/medicines/inhalers etc. regularly?		
Number of cigarettes per day _____ Alcohol intake _____		

ICO will not take responsibility for failure to disclose any physical or medical condition that could affect your participation in this competition. I understand that the Doctor must pass me fit to fight.

Blood pressure OK {please tick} ☐ Cardio Respiratory OK {please tick} ☐

Physicality OK {please tick} ☐ No signs of substance misuse {please tick} ☐

Notes;

Signature of Fighter: _____ Date: _____

Signature of Medic: _____ Date: _____