



# WORLD KICKBOXING ASSOCIATION

(804) 977 6249 (FAX)  
admin@wkausa.com



**World Kickboxing Association**  
Comprehensive Amateur Physical Examination Report  
Front To be Completed by Fighter

Name of Event: \_\_\_\_\_ Date of Event: \_\_\_\_\_  
 First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB: \_\_\_\_\_  Male  Female  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Country: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ \*\* Will receive WKA Fighter License via email  
 Email: \_\_\_\_\_  
 Do you have a Health Insurance?  yes  no If so, with what company? \_\_\_\_\_

**Medical History:**  
 Have you ever had, or do you currently have any of the following conditions? Please check boxes of all that apply.

|   |   |
|---|---|
| 1. Blood Disorder or Anemia                                 | 19. Hepatitis                                   |
| 2. Seizure or Convulsions                                   | 20. Diabetes                                    |
| 3. Rheumatic Fever  | 21. Physical Impairment                         |
| 4. Asthma or Shortness of Breath                            | 22. Skin Disease or Rash                        |
| 5. High Blood Pressure                                      | 23. Chronic Cough                               |
| 6. Heart Disease or Heart Murmur                            | 24. Headaches                                   |
| 7. Chest pain, discomfort, or pressure                      | 25. Swollen Joint, Joint Injury, or Dislocation |
| 8. Tuberculosis   | 26. Sprain, Muscle or Ligament Tear, Tendonitis |
| 9. Marfan Syndrome  | 27. Severe muscle cramps                        |
| 10. Rheumatism or Arthritis                                 | 28. Neck or Spine disorder or instability       |
| 11. Sickle Cell Disease or trait (in self or family member) | 29. Spitting or Coughing of Blood               |
| 12. Kidney, Lung, Testicle or Eye removed                   | 30. Surgery or Hospitalization                  |
| 13. Kidney Disease, Single or Horseshoe kidney              | 31. Substance Abuse                             |
| 14. Concussion or Unconsciousness                           | 32. Communicable Disease                        |
| 15. Mononucleosis   | 33. Fracture or Stress Fracture                 |
| 16. Allergies   |   |
| 17. Blurring of Vision or other eye/vision problems         |   |
| 18. Wear/ have worn Glasses or Contact lenses               |   |

Name of Primary Care Physician / Family Doctor: \_\_\_\_\_  
 If you checked any of the above boxes, please explain  
 \_\_\_\_\_  
 Do you have any other information concerning your health (if yes, describe fully): \_\_\_\_\_  
 \_\_\_\_\_

**Comments:**  
 I have examined the above contestant on (date): \_\_\_\_\_  
 This athlete shows no physical findings that would prohibit his/her participation in the listed event.  
 This athlete should have close follow up for the following conditions, by his/her primary care physician.  
 This athlete should not compete today.

Are you taking any Medications or Drugs? \_\_\_\_\_ Please list and give the name of the prescribing doctor:  
 \_\_\_\_\_

Date of Last Fight: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 How Many Knock Outs have you suffered? KO \_\_\_\_\_ TKO \_\_\_\_\_ Date of Last KO \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Longest duration of unconsciousness \_\_\_\_\_ (# of min, hour, days)  
 Length of time before returning to contact \_\_\_\_\_  
 Have you ever been knocked unconscious in any other sport or activity? \_\_\_\_\_  
 What is your average non-fight weight? \_\_\_\_\_  
 Signature of Fighter: \_\_\_\_\_

Please ensure that the box has been ticked by your Dr to clear you to compete.  
Physicals that do not have this section completed will be rejected.



Physical must be signed by a Dr not a CRNP, NP or PAC  
**MUST BE A DR**

Your physical **MUST** be signed off or co-signed by a Dr/MD/DO. Physicals signed off by a FRNP, NP, PAC will be rejected. Nurse Practitioners may co-sign a physical with a Dr/MD/DO.  
Bloodwork is **NOT REQUIRED** for Nationals.



# World Kickboxing Association



8032 W. Broad St.  
Richmond, VA 23294

Richmond, Virginia

**804-525-4780**

(804) 977-6249 (fax)  
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www.WKAUSA.com

## Attention Fighter:

Listed below are the requirements for fighters on all WKA-sanctioned cards. Please print your physical form and this cover letter and take them to your physician:

- Fighter physical - please fill out the first page of your physical BEFORE going to the doctor's office. This is the page where you fill in your medical history for the doctor to review before he/she completes the examination on the subsequent page (amateur) or pages (professional). Physicals missing the portion to be completed by the fighter will NOT be accepted.
- All medicals must be received **NO LATER** than two weeks before your fight.

## Physicians' Guide:

### Physical:

- ALL pages of the physical must be filled out and included. Please ensure that the fighter has filled out the first page of the physical and that you have reviewed it so that you are familiar with the fighter's medical history **before** completing the examination portion and that you fax the physical in its entirety.
- Please remember to fill in the fighter's name on each page of the physical.
- Please date the physical with the examination date next to your signature.
- Please remember to check the box/bubble that indicates whether or not the fighter is cleared to participate. A completed physical alone does not necessarily indicate to us whether or not a fighter is medically fit to participate - thus, we have included a box that you can check to indicate this.

### Sending a Fighter's Physical/Bloodwork:

- **Submit Online:** <https://airtable.com/appIGufrqQkFCbRvo/pagQFss2SthiSPk1z/form>
- Or, fax directly to the WKA at **(804) 977-6249** from the doctor's office and/or lab.
- Additionally, please keep hard copies for yourself.

If you have any questions, please e-mail our administrative office at [admin@wkausa.com](mailto:admin@wkausa.com)



WKA Medical Portal



# World Kickboxing Association



## Amateur 35+ YO Physical Examination Report

### Front To be Completed by Fighter

Name of Event: WKA National Championships Date of Event: 14-16 August, 2026  
 First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB: \_\_\_\_\_  Male  Female  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Country: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_  
 Email: \_\_\_\_\_ **\*\* Will receive WKA Fighter License via email**  
 Do you have a Health Insurance?  yes  no If so, with what company? \_\_\_\_\_

### Medical History:

Have you ever had, or do you currently have any of the following conditions? Please check boxes of all that apply.

|   |   |  |
|---|---|--|
| 1. Blood Disorder or Anemia                                 | 19. Hepatitis                                       |  |
| 2. Seizure or Convulsions                                   | 20. Diabetes  |  |
| 3. Rheumatic Fever  | 21. Physical Impairment                             |  |
| 4. Asthma or Shortness of Breath                            | 22. Skin Disease or Rash                            |  |
| 5. High Blood Pressure                                      | 23. Chronic Cough                                   |  |
| 6. Heart Disease or Heart Murmur                            | 24. Headaches                                       |  |
| 7. Chest pain, discomfort, or pressure                      | 25. Swollen Joint, Joint Injury, or Dislocation     |  |
| 8. Tuberculosis   | 26. Sprain, Muscle or Ligament Tear, Tendonitis     |  |
| 9. Marfan Syndrome  | 27. Severe muscle cramps                            |  |
| 10. Rheumatism or Arthritis                                 | 28. Neck or Spine disorder or instability           |  |
| 11. Sickle Cell Disease or trait (in self or family member) | 29. Spitting or Coughing of Blood                   |  |
| 12. Kidney, Lung, Testicle or Eye removed                   | 30. Surgery or Hospitalization                      |  |
| 13. Kidney Disease, Single or Horseshoe kidney              | 31. Substance Abuse                                 |  |
| 14. Concussion or Unconsciousness                           | 32. Communicable Disease                            |  |
| 15. Mononucleosis   | 33. Fracture or Stress Fracture                     |  |
| 16. Allergies   | 34. Rupture or Hernia                               |  |
| 17. Blurring of Vision or other eye/vision problems         | 35. Dizziness or Fainting Spells                    |  |
| 18. Wear/ have worn Glasses or Contact lenses               | 36. Numbness, weakness, or tingling in arms or legs |  |

Name of Primary Care Physician / Family Doctor: \_\_\_\_\_

If you checked any of the above boxes, please explain fully: \_\_\_\_\_

Do you have any other information concerning your health, past or present, which is not covered by the above questions? (if yes, describe fully): \_\_\_\_\_

Are you taking any Medications or Drugs? \_\_\_\_\_ Please list and give the name of the prescribing doctor: \_\_\_\_\_

Date of Last Fight: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 How Many Knock Outs have you suffered? KO \_\_\_\_\_ TKO \_\_\_\_\_ Date of Last KO \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Longest duration of unconsciousness \_\_\_\_\_ (# of min, hour, days)  
 Length of time before returning to contact \_\_\_\_\_  
 Have you ever been knocked unconscious in any other sport or activity? \_\_\_\_\_  
 What is your average non-fight weight? \_\_\_\_\_

Signature of Fighter: \_\_\_\_\_



**To be Completed by Physician**

**Physical Examination for:** \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Temperature: \_\_\_\_\_ Pulse: \_\_\_\_\_

General appearance: \_\_\_\_\_

HEENT: \_\_\_\_\_

Pupils: Reg \_\_\_\_\_ Round \_\_\_\_\_ Equal \_\_\_\_\_ React Light \_\_\_\_\_ Accom \_\_\_\_\_

OD \_\_\_\_\_ OS \_\_\_\_\_ Periorbital scars \_\_\_\_\_

Acuity \_\_\_\_\_

Oropharynx: \_\_\_\_\_

Neck: LA \_\_\_\_\_ Goiter \_\_\_\_\_ ROM \_\_\_\_\_

Lungs: \_\_\_\_\_

Heart: \_\_\_\_\_

Abd: \_\_\_\_\_

Inguinal region: \_\_\_\_\_

Cervical Spine/Neck: \_\_\_\_\_

Back: \_\_\_\_\_

Shoulders: \_\_\_\_\_

Arm/Elbow/Wrist: \_\_\_\_\_

Knees: \_\_\_\_\_

Ankles: \_\_\_\_\_

Hips: \_\_\_\_\_

Hands/Feet/Small Joints: \_\_\_\_\_

Skin: \_\_\_\_\_

Neuro: \_\_\_\_\_

Gait: \_\_\_\_\_ Romberg: \_\_\_\_\_ FNF: \_\_\_\_\_ RAM: \_\_\_\_\_

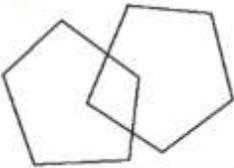
Muscle stretch reflexes: \_\_\_\_\_ Motor: \_\_\_\_\_ Sensory: \_\_\_\_\_

Orientation: Self, time, place: \_\_\_\_\_

Mental assessment: \_\_\_\_\_

Physical Examination Continued for: \_\_\_\_\_

MMSE (required for professional fights)

|     |  | Comment | Score | Poss |
|-----|--|---------|-------|------|
| 1.  | Year, season, month, date, day   |         |       | (5)  |
| 2.  | Where are we? State, county, city, building, floor   |         |       | (5)  |
| 3.  | Repeat names of 3 objects (e.g.: ball, apple, cow)   |         |       | (3)  |
| 4.  | Serial 7's 100, 93, 86, 79, 72, 65   |         |       | (5)  |
| 5.  | Recall: repeat the three objects again   |         |       | (3)  |
| 6.  | Name identified objects (e.g.: pen and watch)  |         |       | (2)  |
| 7.  | Repeat sentence (e.g.: "No ifs, ands, or buts")  |         |       | (1)  |
| 8.  | Follow three-step command (e.g.: take paper in your hand, fold it in half, and put it on the floor.) |         |       | (3)  |
| 9.  | Copy design<br>     |         |       | (1)  |
| 10. | May comment on reading, writing ability  |         |       |      |

A total score of 0-21 suggests cognitive impairment

Total score: \_\_\_\_\_

Other physician observations : \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I have examined the above contestant on (date): \_\_\_\_\_

- This athlete shows no physical findings that would prohibit his/her participation in the listed event.
- This athlete should have close follow up for the following conditions, by his/her primary care physician.
- This athlete should not compete today.

Comments: \_\_\_\_\_

Doctor's Signature: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Practice/Company (if applicable): \_\_\_\_\_

Doctor's License Number: \_\_\_\_\_ State of License: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_