



RING CONTACT FIGHTING ARTS

MEDICAL FORM

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Province	Club /Gym Name & Address	Passport/ Identity No:

Family Name	Given Name	Middle Name	Nationality/Citizenship
Weight	Pulse(min)	Blood Pressure (mmHg)	
Skin Exam:		Infection	
		Dermatologic disorders	
		Lesions	
Head & Face:		Any bruises, scars, swelling or tenderness	
Eyes:	Pupils, Right	Cornea Left	
	Distance Vision: Right	Distance Vision: Left	
Ears:	Hearing Right:	Hearing Left:	
Throat:			
Nose			
Teeth:	(Summary of dental exam)		
Neck:	Is it freely moveable and without pain? Evaluate of lymphatic glands & thyroid		
Chest:	Any deformities		
Lungs:			
Heart:	Rhythm		
	Size		
Extremities	With special attention to the hands		
	Bones		
	Joints Skin		
	Nails		
Lung exam			
Neurological Examination			
Locomotor System	Any scars, tenderness, swelling, muscular atrophy, restrictions or laxity of joints, any deformities of the back or restriction of spinal mobility?		
Nervous System	Any tremors of eyelids, tongue or outstretched fingers?		
Genitalia	Absent or undescended testicles, hydrocele, varicocele, inguinal or femoral hernia?		

Declaration:

This person MAY | MAY NOT practice and compete in martial arts.

Doctor Signature	Date: (DD/MM/YY)	Official Stamp
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Student Signature / Parent Signature if student is a minor	Date: (DD/MM/YY)	Instructor Signature	Date: (DD/MM/YY)
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