



# MARTIAL ARTS SOUTH AFRICA



## MEDICAL FORM

<b>PROVINCE:</b>		<b>CLUB/GYM NAME:</b>		<b>PASSPORT/IDENTITY NO:</b>	
<b>CLUB/GYM ADDRESS:</b>					
<b>NAME:</b>		<b>SURNAME:</b>		<b>MIDDLE NAME:</b>	
<b>WEIGHT:</b>		<b>PULSE(MIN)</b>		<b>BLOOD PRESSURE (mmHg):</b>	
<b>SKIN EXAM:</b>		<b>INFECTION:</b>		<b>DERMATOLOGIC DISORDERS:</b>	
				<b>LESIONS:</b>	
<b>HEAD &amp; FACE:</b>				<b>ANY BRUISES, SCARS, SWELLING OR TENDERNESS</b>	
<b>EYES:</b>		<b>PUPIL, RIGHT</b>		<b>PUPILS, LEFT</b>	
		<b>DISTANCE VISION: RIGHT</b>		<b>DISTANCE VISION: LEFT</b>	
<b>EARS:</b>		<b>HEARING RIGHT</b>		<b>HEARING LEFT</b>	
<b>THROAT:</b>		<b>NOSE:</b>		<b>TEETH: (SUMMARY OF DENTAL EXAM)</b>	
<b>NECK:</b>		Is it freely moveable and without pain? Evaluate of lymphatic glands & thyroid			
<b>CHEST: Any deformities</b>					
<b>LUNGS:</b>					
<b>HEART: Rhythm</b>				<b>Size:</b>	
<b>EXTREMITIES:</b>		With special attention to the hands			
		Bones			
		Joint Skin			
		Nails			
<b>LUNG EXAM:</b>					
<b>NEUROLOGICAL EXAMINATION:</b>					
<b>LOCOMOTOR SYSTEM</b>		Any scars, tenderness, swelling, muscular atrophy, restrictions or laxity of joints, any deformities of the back or restriction of spinal mobility?			
<b>NERVOUS SYSTEM:</b>		Any tremors of eyelids, tongue, or outstretched fingers?			
<b>GENITALIA:</b>		Absent or undescended testicles, hydrocele, varicocele, inguinal or femoral hernia?			
<b>DECLARATION:</b>		Practice and compete in martial arts.			
This person		<b>MAY</b>	<b>MAY NOT</b>		
<b>DOCTORS SIGNATURE</b>		<b>DATE: (DD/MM/YY)</b>		<b>OFFICIAL STAMP</b>	

Student Signature / Parent Signature if student is a minor

DATE: (DD/MM/YY)

Instructor Signature

DATE: (DD/MM/YY)

North West Secretary Contact Details: Verischke Lubbe 09 16 2616 nwsecretary@martialart.co.za