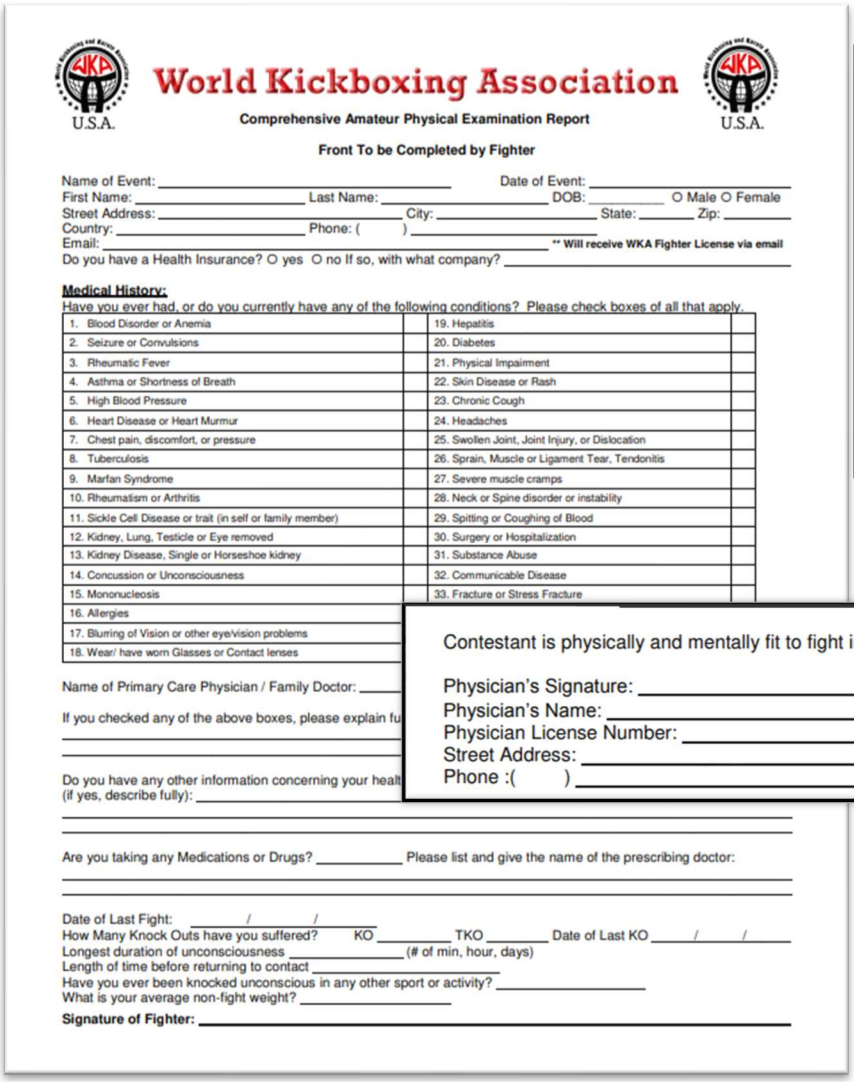
WORLD KICKBOXING ASSOCIATION

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



World Kickboxing Association

U.S.A.

Comprehensive Amateur Physical Examination Report

Front To be Completed by Fighter

Name of Event: _____ Date of Event: _____
First Name: _____ Last Name: _____ DOB: _____ O Male O Female
Street Address: _____ City: _____ State: _____ Zip: _____
Country: _____ Phone: ( ) _____
Email: _____ ** Will receive WKA Fighter License via email
Do you have a Health Insurance? O yes O 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 fu

Do you have any other information concerning your healt
(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: _____

Please ensure that the YES circle has been ticked by your Dr to clear you to compete.

Physicals that do not have this section completed will be rejected.

Contestant is physically and mentally fit to fight in a Combative Martial Arts competition. O Yes O No

Physician's Signature: _____ Date of Exam: ___/___/___
Physician's Name: _____ Practice/Company (if applicable): _____
Physician License Number: _____ State of License: _____
Street Address: _____ City _____ State: _____ Zip: _____
Phone :( ) _____

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)
admin@wkausa.com
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.

Physicans' 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/applGufrgQkFCbRvo/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

WKA Medical Portal

World Kickboxing Association

U.S.A.

Comprehensive Amateur Physical Examination Report

U.S.A.

Front To be Completed by Fighter

Name of Event: WKA National Championships Date of Event: 21-24 August, 2025
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: _____ Rhomberg: _____ FNF: _____ RAM: _____

Muscle stretch reflexes: _____ Motor: _____ Sensory: _____

Orientation: Self, time, place: _____

Mental assessment: _____

Contestant is physically and mentally fit to fight in a Combative Martial Arts competition. **O Yes** **O No**

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 :( ) _____