MIXED MARTIAL ARTS AUSTRALASIA INC.

COMBAT SPORT CONTESTANTS & PARTICIPANTS
ANNUAL MEDICAL EXAMINATION

Full Name: ____________________
Address: ____________________
____
City: ____________________ State: __________ P/C: __________

Proof of ID: Drivers License/Passport Sighted Yes No

Birth Date: ____/____/____ Sex: Male Female

I CERTIFY THAT THAT ABOVE MENTIONED PERSON ATTENDED FOR A MEDICAL INSPECTION ON:
____/____/20____

Have you previously, or do you suffer from:

				Comments:
1	Fainting	Yes	No	
2	Epilepsy	Yes	No	
3	Cardiac Disorder	Yes	No	
4	Neurological Disorders	Yes	No	
5	Severe Headaches	Yes	No	
6	Migraine	Yes	No	
7	Renal or Bladder Disease	Yes	No	
8	Respiratory Issues	Yes	No	
9	Mental Illness	Yes	No	
10	Disability	Yes	No	
11	Any other disorder	Yes	No	
12	Hospitalisation in past 12mths	Yes	No	

Have you been knocked unconscious/suffered concussion in competition, training or other in the last:

60 Days:	Yes	No	Details:
6 Months:	Yes	No	Details:
12 Months:	Yes	No	Details:

Height (cm): __________ Weight (kg): __________ Reach (cm): __________
Waist (cm): __________ Chest (cm): __________ Chest Exp (cm): __________
B.P: __________

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COMBAT SPORT CONTESTANTS & PARTICIPANTS
PRE COMPETITION MEDICAL REPORT

Examination Comparison:

Normal = N Abnormal = A

Head	________	Face	________	Visual Field	________
Eyes	________	Feet	________	Shoulder Rotation	________
Heart	________	Gums	________	Elbow Rotation	________
Hearing	________	Lungs	________	Hip Rotation	________
Abdomen	________	Spine	________	Knee Rotation	________

Comments: ______________________________

Has this person displayed any evidence (physical, mental, emotional or other) that would deny them entry into a combat sport competition? **Yes** **No**

If Yes, provide details: ______________________________

I, ______________________ consider the above named person FIT/UNFIT for competition.

(Practioner Name)

Medical Practitioner Signature

Date

Practitioner Stamp and/or Contact Details.

MIXED MARTIAL ARTS AUSTRALASIA

Combat Sports Contestants & Participants

SEROLOGY REPORT

Medical Practitioners Report

I certify that;

Full name of Contestant/Participant: ______________________________

Address: ____

Suburb: ____________________ State: ______________ P/C: ________

Date of Birth: ______________ Sex: **M / F**

Proof of ID: Drivers License/Passport Sighted YES NO

Attended for H.I.V., Hepatitis B Antigen and Hepatitis C on: ____/____/____

TEST RESULTS			
i.	HIV	NEGATIVE	OTHER
ii.	HEPATITIS B ANTIGEN	NEGATIVE or IMMUNE	OTHER
iii.	HEPATITIS C	NEGATIVE	OTHER

COMMENTS ON RESULTS NOT NEGATIVE OR IMMUNE

Medical Practitioners Signature: ____________________________ DATE: ___/___/___

Name of Medical Practitioner (please print)	Telephone #
Address of Practice	