Athletics Commission of Saskatchewan

# COMPLETE PHYSICAL EXAMINATION FORM

*INSTRUCTIONS: Only this form created by the Athletics Commission of Saskatchewan will be accepted in order to satisfy the requirement. This completed form can be emailed to acs@gov.sk.ca, faxed to 306-787-5523, or mailed to the Athletics Commission of Saskatchewan, 1st Floor—3211 Albert St, Regina, Saskatchewan, S4S 5W6.*

**APPLICANT INFORMATION (to be completed by the applicant)**

| Full name of applicant *(first, middle, last):* | Date of birth *(month, day, year):* |
|---|---|
| | |

Address *(street address, city, province/state, postal code/zip code, country):*

| Primary telephone no. *(include area code):* | Business telephone no. *(include area code):* |
|---|---|
| | |

| Sex *(male or female):* | Height: | Weight: |
|---|---|---|
| | | |

| Amateur Boxing Record | Amateur Mixed Martial Arts Record | Other Amateur Combative Sport Record |
|---|---|---|
| Wins_____Losses_____Draw_____ | Wins_____Losses_____Draw_____ | Wins_____Losses_____Draw_____ |

| Pro Boxing Record | Pro Mixed Martial Arts Record | Other Pro Combative Sport Record |
|---|---|---|
| Wins_____Losses_____Draw_____ | Wins_____Losses_____Draw_____ | Wins_____Losses_____Draw_____ |

**MEDICAL HISTORY (to be completed by the applicant)**

Have you ever had any of the following conditions?

| | | | |
|---|---|---|---|
| ☐ Fainting spells | ☐ Rupture (hernia) | ☐ Chest pains | ☐ Operations |
| ☐ Shortness of breath | ☐ Swollen joints | ☐ Rheumatism | ☐ Diabetes |
| ☐ Frequent headaches | ☐ Convulsions (fits) | ☐ Chronic cough | ☐ Asthma |
| ☐ Bleeding disorders | ☐ Palpitations (racing heart rate) | ☐ Seizures | ☐ Allergies |
| ☐ Cerebral hemorrhage or any other serious head injury | | ☐ Spitting of blood | ☐ Concussion |
| ☐ Hearing problems | ☐ Facial injuries | ☐ Thyroid disorders | ☐ Ulcers |
| ☐ Kidney disease | ☐ Pinched nerve | ☐ Broken bone | |

If "Yes" to any of the above, explain: _____

_____

Have you seen a doctor for any medical problem in the last 3 months? If yes, explain: _____

_____

Do any diseases run in your family? _____

_____

Number of knockouts received:_____ Date of last knockout (*month, day, year):* _____

Longest duration of unconsciousness: _____

Length of time before resuming combative sports after last knockout: _____

Have you ever been knocked unconscious in other sport or in any other way? If yes explain:_____

_____

**PHYSICAL EXAMINATION** ***(to be completed by the examining medical practitioner)***

Pulse at rest: _____ Pulse after 100 hops: _____

Blood pressure at rest: _____ Blood pressure after 100 hops: _____

**GLANDS**

Enlarged (yes/no): _____ Goiter (yes/no): _____

**HEART**

Pulse rhythm (regular/irregular): _____ Apical impulse (heavy/normal): _____

Enlargement (yes/no): _____ Murmurs (yes/no): _____

**LUNGS**

Rales (yes/no): _____

**BREASTS**

Mass (yes/no): _____ Tenderness (yes/no): _____ Discharge (yes/no): _____

**ABDOMEN**

Enlargement of liver (yes/no): _____ Enlargement of spleen (yes/no): _____

Hernia (yes/no): _____ If yes, femoral, inguinal or ventral: _____

**TESTICLES**

Normal (yes/no): _____

**REFLEXES**

Pupils: _____ Knee jerks: _____ Romberg: _____ Babinski: _____

**SKIN**

Rash: _____ Boils: _____ Any other unhealed wounds: _____

Medications:

**DIAGNOSTICS** ***(The original lab report with applicant's name and date the tests were performed must be submitted)***

1. HIV
2. Hepatitis B ***(ANTIGEN REPORT REQUIRED EVEN IF IMMUNIZED)***
3. Hepatitis C
4. *Women only:* Pregnancy ***(LAB TEST WITHIN 7 DAYS PRIOR TO EVENT)***

**CERTIFICATION (*to be completed by the examining medical practitioner)***

I hereby certify that based on the statements made by the applicant on the reverse side of this form, my physical findings, and pending any medical testing not yet reviewed, it is my opinion that _____ ☐ **IS** ☐ or **IS NOT** in good physical condition and is medically cleared to be licensed as a competitor in a combative sport.

Reason not cleared for competition: _____

Name of medical practitioner (print): _____ Signature:_____

Date of examination: _____

Office address: _____ Telephone number: _____

E-mail: _____ Fax: _____