RING CONTACT FIGHTING ARTS

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MEDICAL FORM

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 of restriction of spinal mobility?	
Nervous System	Any tremors of eyelids, tongue or outstretched fingers?	
Genitalia	Absent or undescended tactical, hydrocele, varicocele, inguinal or femoral heria?	

Declaration: This person may or may not practise and compete in martial arts.

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Signature of Doctor

Student Signature/ Parent Signature if student junior ____________	Date: (DD/MM/YY) ____________
Instructors Signature ____________	Date: (DD/MM/YY) ____________