FLORIDA STATE BOXING COMMISSION

1940 North Monroe Street, Tallahassee, Florida 32399-1016 (850) 488-8500 fax (850) 922-2249

PARTICIPANT INFORMATION AND MEDICAL SHEET

SECTION 1. – TO BE COMPLETED BY PARTICIPANT

Legal Name: ______________________________ Ring Name: ____________________
(Last) (First) (Middle)

Age: ________ Date of Birth: ________________
Month/Day/Year

Manager's Name: ____

Print names of each person who will be working in your corner. Note: You may have 3 people working in your corner except in the case of a championship fight when you may have 4 people working in your corner.

(Please Print)

1. ______________________ 3. ______________________

2. ______________________ 4. ______________________

Medical History			
Have you ever been treated for an ongoing medical condition?			
▶ If yes, what was the medical condition?			
Have you had any previous surgeries?			
▶ If yes, list the type of surgery and date:			
Have you ever suffered a cerebral hemorrhage or a serious head injury?			
▶ If yes, list when and type of head injury:			
Do you now, or have you ever had asthma?			
Have you had an EKG in the past 12 months?			
▶ If yes, where was it performed?			
Have you had an EEG in the past 12 months?			
▶ If yes, where was it performed?			
Have you had a CT Scan or MRI in the past 12 months?			
▶ If yes, where was it performed?			
Have you ever been knocked unconscious?			
▶ If yes, when?			
Have you ever had headaches, blurring of vision or dizziness?			
▶ If yes, when?			
▶ If yes, how often?			
Have you had any recent joint sprains/strains?			
Have you had any accident or injury while training for this match?			
Have you consulted a doctor for any medical condition while training for this match?			
Have you been ill in any manner whatsoever during the past two (2) weeks?			

Have you ever had have any blindness or poor vision in either eye?			
Have you ever had temporary loss of vision?			
Have you had an ophthalmic (eye) examination in the past 12 months?			
Have you ever had any eye diseases?			
Have you ever suffered an eye injury?			
Have either of your eyes been operated on for detached retina or for any other reason?			
Do you have any pre-existing medical condition(s) not previously listed?			
▶ If yes, list:			
Are you now taking or have you taken in the past week any drugs or medicines other than vitamins?			
▶ If yes, list:			
Are you now taking or have you taken any aspirin products to include Aleve, Ibuprofen, Motrin, Advil or any other blood thinning?			
▶ If yes, list to include when, dosage and how often:			
Are you allergic to any drugs or medicine?			
▶ If yes, list:			

I, the undersigned, state that I am the person referred to in this document, in the State of Florida, and I have completed this form to the best of my knowledge.

I understand that making a misstatement of a material fact, fraudulently concealing a material fact, or inducing or aiding another person in misstating or concealing any material fact in any application or other proceeding may result in administrative action, including a fine, suspension or revocation of the license, pursuant to s. 548.071, F.S.

KNOWINGLY MAKING A FALSE STATEMENT IN WRITING WITH THE INTENT TO MISLEAD A PUBLIC SERVANT IN THE PERFORMANCE OF HIS OFFICIAL DUTY IS A MISDEAMEANOR OF THE SECOND DEGREE. s. 837.06 F.S.

I hereby authorize the Florida State Boxing Commission to have immediate and unlimited access to any and all medical records which may relate to my fitness to participate in a boxing, kickboxing, or mixed martial arts match and to any medical records related to an injury or suspected injury sustained as a result of a match. I authorize the release of any and all medical records which may relate to my fitness to participate in a boxing, kickboxing, or mixed martial arts match and to any medical records related to an injury or suspected injury sustained as a result of a match to the ringside physicians assigned to provide medical care at the match for which I intend to participate for the purposes of determination of my fitness to participate. I further authorize the release of any and all medical records which may relate to my fitness to participate in a boxing, kickboxing, or mixed martial arts match and to any medical records related to an injury or suspected injury sustained as a result of a match to any commission of any state or jurisdiction of the United States or foreign country, or any other regulatory body responsible for regulating boxing, kickboxing, or mixed martial arts.

I understand that the medical record released pursuant to this authorization could contain medical information which is subject to federal and/or state restrictions on disclosure. I have read and fully understand the above statements and consent to the disclosure of the medical records for the purpose and extent stated above.

______________________________ ______________

Signature of Applicant **Date**

FOR COMMISSION USE ONLY:

Required sections to be completed by Ringside Physician:

☐ **Section 2: Physical Examination**

☐ **Section 3: Certification by Attending Ringside Physician**

SECTION 2. – PHYSICAL EXAMINATION TO BE COMPLETED BY PHYSICIAN

(A check or no entry indicates normal findings)

- Temperature: ______________ Weight: ________________
- Eyes: Pupils. Regular: ____________ Equal: ____________ React to light and accommodation: ______________

  Periorbital and lid regions (describe any scars or abnormalities): ____
- Ears (discharge, etc): ____
- Lungs (abnormal breath sounds, friction rub, rales, etc.): ____
- Blood Pressure: _____________________________

HEENT:	Normal/Negative	Abnormal/Comment
EOMI		
PERLA		
Nystagmus		
Scars/ecchymoses		
Turbinates/hematoma		
Throat		
Nodes		
Thyroid		

Lungs/Chest Wall	Normal/Negative	Abnormal/Comment
Pectus excavatum		
Pectus carinatum		
Symmetrical		
Rib tenderness/ ribs intact		
Masses/nipple discharge/piercings		
Auscultation/percussion		

Cardiac:	Normal/Negative	Abnormal/Comment
Regular rhythm		
Resting pulse appropriate for athlete		
Ectopy		
Murmur		
Abdomen:	**Normal/Negative**	**Abnormal/Comment**
Bowel Sounds + x4		
Soft/ non-tender		
Organomegaly		
Hernia		

Skin:	Normal/Negative	Abnormal/Comment
Cellulitis		
Alopecia		
Scars		
Piercings		
Pulses (brachial/radial/fem/DP)		

Back:	Normal/Negative	Abnormal/Comment
Curvature		
ROM		
Tenderness		

Ortho: circle affected body part(s)	Normal/Negative	Abnormal/Comment

Muscle symmetry/atrophy		
NECK/ SHOULDERS/ WRISTS/ HANDS/ DIGITS/ HIPS/ KNEES/ ANKLES/ FEET		
a. Tenderness		
b. Edema		
c. Ecchymoses		
d. ROM		
e. Fracture/dislocation		
f. Contusions		

Neuro:	Normal/Negative	Abnormal/Comment
Alertness		
Orientation x3		
DTR: (biceps/triceps/ patellar)		
Babinski		
Rhomberg		
Finger to nose		
Heel to shin		
Abnormal movements		
a. Tics		
b. Choreiform		
c. Fasciculations		

Genitalia:	Normal/Negative	Abnormal/Comment
Herpes gladiatorum		
Rashes		
Open lesions		
External		
Testicular mass		
Varicocoele		
Lesions		
Hernia		
External hemorrhoids		
Breast masses, nipple discharge, piercings		
Implants: Saline or silicone, surgery date		
Pelvic masses		
Lesion, external genitalia		
Pregnancy results/recent pregnancy (date of delivery)		

Prior surgeries, dates:

1. ______________________________
2. ______________________________
3. ______________________________

Pre-existing medical conditions:

1. ______________________________
2. ______________________________
3. ______________________________

Please attach additional documentation, test results or additional paper as needed to complete this form.

Remarks: ______________________________

SECTION 3. – CERTIFICATION BY ATTENDING RINGSIDE PHYSICIAN

I hereby certify that based on the statements made by the participant listed above and my physical findings, it is my opinion that said participant:

☐ Is in good physical condition and able to engage in a boxing, kickboxing or mixed martial arts match.
☐ Is not in appropriate physical condition to engage in a boxing, kickboxing or mixed martial arts match.

Date of Examination: ____________

Please Print Name of Examining Ringside Physician:________________________

Signature of Ringside Physician: ____