Head Quarters: 5425 Nectar Circle, Elk Grove, CA. 95757

Email: aquesada.iska.ca@gmail.com

AMATEUR ATHLETE PHYSICAL EXAMINATION KICKBOXING

Only a licensed Physician (MD or DO) may conduct this examination in person and complete this form.

Please complete this form in its entirety.

NOTE TO PHYSICIAN: PLEASE EMAIL COMPLETED FORM TO; iska.california@gmail.com

Last Name, First Name, Middle Name

Address: **Street (No PO BOX) City State Zip Code Country**

Telephone number:
Email:

Male / Female (circle one)	**Age:**	**Date of Birth:** **(MM / DD / YYYY):**

PHYSICAL HISTORY: Please circle all that applies below: Asthma, Blood in urine, Allergies, Fainting spells, Rupture (hernia), Chest pains, Operations, Shortness of breath, Swollen joints, Rheumatism, Diabetes, Frequent headaches, Convulsions (fits), Chronic cough, Spitting of blood, Cerebral hemorrhage, or serious head injury. If yes, please explain: ____

____

When was the last time you took any type of medication or drug? (State what type and when and be specific):

____

Have you ever undergone any type of surgery? Yes No (State what type and when and be specific):

____

When was the last time you took any type of vitamin supplement? (State what type and when and be specific):

____

Amateur Record:

Kickboxing: W: _____L: _____ Muay Thai: W: _____L:_____

Boxing: W: _____L: _____ MMA: W:: _____L:: _____

Comments:

AMATEUR ATHLETE PHYSICAL EXAMINATION

APPLICANT NAME: ______________________________________

PHYSICAL EXAMINATION:

General appearance: _______________________Height: ________Weight: __________
Temperature: ________Disabling scars: ____________Mouth: ____________Teeth: _____________Tonsils: _________ Neck: _________Pulse at rest: __________Pulse after 100 hops: ____________

Blood pressure at rest: __________After 100 hops: ____________2 minutes later: ___________Enlarged glands: **Yes No**

Goiter: **Yes No** Heart: Pulse rhythm (circle one) **Regular Irregular** Murmurs: **Yes No** Musculoskeletal system:
____

Apical impulse (circle one): **Heavy Normal** Enlargement: **Yes No** Lungs: Rales **Yes No**

Abdomen: Enlargement of liver **Yes No** Breasts: Mass **Yes No** Tenderness **Yes No**

Discharge **Yes No** Enlargement of Spleen: **Yes No** Hernia: **Yes No** Testicles: Normal **Yes No**
Remarks:____

Reflexes: Pupils ___________Knee jerks _____________Romberg ____________Babinski ____________

Skin: Tone ___________Rash ___________Boils ___________Other:_________________Unhealed wounds:__________

Remarks: ____

The information contained on this form is maintained by ISKA California at 5425 Nectar Circle, Elk Grove, CA.95757. All items of information are mandatory; none are voluntary. Failure to provide any of the requested information will delay the processing of your application or result in your application being rejected as incomplete. The information provided will be used to determine your qualifications for licensure pursuant to Business and Professions Code Section 18640.
The information on your application may be transferred to other governmental or law enforcement agencies. You have the right to review records maintained on you by the ISKA Organization unless the records are identified as confidential information pursuant to the Public Records Act or are exempted by Section 1798.40 of the Civil Code. You may gain access to the information by contacting ISKA California at the address above.

EXAMINING PHYSICIAN:

Based on your personal observation and review of the test results and considering Commission rules, is it your medical opinion that this applicant is physically fit to be licensed and compete in combative sports? **Yes No**

If no, please explain:

Nurse Practitioner will not be ACCEPTED!

Print MD or DO Name: **Medical License #**

LICENSED PHYSICIAN'S MD or DO ONLY - NAME (print) MEDICAL LICENSE NO. (Stamp)

ATHLETES NAME (print) **ATHLETES SIGNATURE**

ADDRESS / CITY / STATE / ZIP CODE

TELEPHONE NO. **DATE/TIME**

PHYSICIAN'S SIGNATURE **PRINT NAME of MD or DO**