

Fighter Pre & Post Bout Medical Form

Date of fight		Venue		Name		Date of Birth	
Weight		Date of last fight		Current medication		Allergies	
Past medical history							
Examination							
Blood pressure		Pulse		Resp Rate		Sats	ENT <input type="checkbox"/> Normal
							Ophthalmology <input type="checkbox"/> Normal
CNS <input type="checkbox"/> Normal		Cardiovascular <input type="checkbox"/> Normal		Respiratory <input type="checkbox"/> Normal		Chest Wall <input type="checkbox"/> Normal	Abdo <input type="checkbox"/> Normal
Joints/Limbs/Spine <input type="checkbox"/> Normal						Skin <input type="checkbox"/> Normal	
Declaration							
In relation to the above named fighter. With the medical history given to me and my clinical examination, I declare the fighter fit to fight on the above date.				I have not withheld information relating to my health to the examining doctor. I understand that failure to disclose information pertaining to any recent KO, illness, medication or health problems places my health at risk.			
Doctor Signature			Date	Fighter signature			Date
Post Fight							
Outcome <input type="checkbox"/> won <input type="checkbox"/> lost <input type="checkbox"/> draw <input type="checkbox"/> KO <input type="checkbox"/> TKO <input type="checkbox"/> NC <input type="checkbox"/> Points <input type="checkbox"/> Sub				Head/Neurological <input type="checkbox"/> Normal			
Ortho <input type="checkbox"/> Normal				Other injuries			
Lacerations and treatment							
Doctor comments						Suspension	
Doctor signature			Date	Fighter signature			Date

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