Government of South Australia
Office for Recreation, Sport and Racing

MEDICAL EXAMINATION FORM

Issued under the *Boxing and Martial Arts Act 2000* and *Boxing and Martial Arts Regulations 2015*

CONTESTANT DETAILS					
FULL LEGAL NAME:					
DATE OF BIRTH:					
SEX:	**FEMALE** ☐ **MALE** ☐				
RESIDENTIAL ADDRESS:					
SUBURB:		**STATE:**		**P/CODE:**	
PHONE NUMBER:					
EMAIL ADDRESS:					

Pages 1-3 inclusive to be completed by the Contestant

COMPETITION HISTORY:

	WINS	LOSSES	DRAWS
RESULTS			

Have you suffered any injuries while competing? Y ☐ N ☐
If yes, please provide details:

Have you had any headaches, vomiting or problems with speech or vision after a competition? Y ☐ N ☐
If yes, please provide details:

MEDICAL HISTORY:

		Y	N	NOTES:
	Do you presently have an illness or disability?			
	Are you currently receiving medicine, drugs or other treatment?			
	Has an accident or illness recently resulted in more than a week off work?			
	Do you a. drink alcohol b. smoke			
	Have you ever been a patient in any hospital? Reason			
	Do you wear glasses or contact lenses?			

CONTESTANT DETAILS			
FULL LEGAL NAME:		**DATE OF BIRTH:**	

Have you ever had or are you now suffering any of the following:

		Y	N	NOTES:
	Swollen or painful joints (other than through injury)			
	Shortness of breath			
	Pneumonia, bronchitis or pleurisy			
	a. Coughing blood b. Coughing phlegm			
	Tuberculosis			
	a. Asthma b. Other lung disease			
	a. Deafness b. Tinnitus (ringing of the ears)			
	Any visual problems			
	a. Fainting/blackouts c. Giddiness			
	a. Fits or convulsions b. Epilepsy			
	a. Severe headaches b. Migraines			
	a. Nerves/anxiety b. Severe depression c. Mental illness d. Attempted suicide			
	a. Kidney disease b. Bladder disease c. Pain on passing urine d. Blood in urine			
	Frequent indigestion			
	a. Ulcer of stomach b. Ulcer of duodenum			
	a. Gall bladder issues b. Gall stones			
	a. Vomiting blood b. Passing blood through bowels			
	a. Hepatitis or other jaundice b. Liver disease			
	a. Sugar diabetes b. Gout c. Cancer d. Tumour of any type			
	a. Rupture b. Hernia c. Swollen or painful testicles			
	a. Skin sensitivities/issues b. Tendency to bruise or bleed easily			
	a. Concussion b. Severe head injury c. Loss of consciousness			

CONTESTANT DETAILS			
FULL LEGAL NAME:		**DATE OF BIRTH:**	

Have you ever had or are you now suffering any of the following:

		Y	N	NOTES:
	a. Knee injury b. Ankle injury c. Back injury d. Other joint injury or dislocation			
	a. Fractured bones b. Chipped bones			
	Paralysis (including polio)			
	Have you in the past suffered any other significant illness or disability?			
	Are you pregnant?			

Do you suffer from any infectious blood borne disease? Y ☐ N ☐

- HIV
- Hepatitis B
- Hepatitis C

Over the past 5 years, have you either occasionally or regularly, taken any stimulants, sedatives, medications or drugs by mouth or injection? Y ☐ N ☐

If yes, provide details and, if prescribed by a medical practitioner, include the relevant particulars below:

Over the past 5 years have you had any medical examination, advice, treatment or been in hospital? Y ☐ N ☐

If yes, provide particulars of each instance (including x-ray, electrocardiogram or other tests) in the schedule below.

DATE(S)	NAME AND ADDRESS OF DOCTOR AND/OR HOSPITAL	REASON

CONTESTANT DETAILS			
FULL LEGAL NAME:		**DATE OF BIRTH:**	

ON EXAMINATION:
If not examined, record NE.

		ABNORMAL	NORMAL	NOTES:
	a. Head, face, scalp b. Neck R.O.M.			
	a. Nose deformity b. Nose airway			
	a. Mouth, throat b. Speech			
	a. Teeth, gums b. Dentures YES / NO			
	Ears - general - hearing			
	Tympanic membranes			
	Eustachian tubes			
	Eyes - general			
	Visual fields Eye Gaze			
	Eye movements			
	Ophthalmoscopic examination			
	Chest, lungs			
	Heart (if ECG performed, note result in section 82 & enclose F MED 53)			
	Vascular system (include veins)			
	Abdomen (include hernial orifices)			
	Endocrine system			
	External genitalia			
	a. Feet b. Limbs R.O.M. c. Gait			
	a. Spine b. Trunk R.O.M. c. Posture (standing)			
	Nervous system Cranial nerves			
	a. Cerebellum function b. Body balance/coordination			
	a. Muscle tone b. Muscle strength c. Sensation			
	Reflexes			
	Skin			
	Lymphatic system Lymph glands in neck axilae or inguinal regions			
	Emotional stability			
	Identifying marks			
	Frame Small Medium Large			
	Height (cm)			
	Weight (kg)			
	Waist (cm)			

CONTESTANT DETAILS			
FULL LEGAL NAME:		**DATE OF BIRTH:**	

ON EXAMINATION (cont):
If not examined, record NE.

		ABNORMAL	NORMAL	NOTES:
	Urinalysis Albumin Sugar			
	Blood pressure			
	Eyes Colour			
	Distant vision R6 Corr 6 L6 to 6 Near vision: Normal / Abnormal			
	Particulars of any disabilities			

NEURO/PSYCHOLOGICAL EXAMINATION:

		Y	N	NOTES:
	Is there any evidence of a change in character?			
	Has he or she a good memory for recent events and, in particular, recent contests?			
	Does he or she follow conversation with attention and intelligence?			
	Is there any evidence of a tendency to violence outside the competitive arena?			
	Is further assessment required?			

Details of identification presented (e.g. driver's licence)	

As per Section 5(1)(b) of the *Boxing and Martial Arts Regulations 2015*

MRI SCAN:

Date of MRI Scan: _____ / _____ / _____

Is the MRI scan results satisfactory? Y ☐ N ☐

Any further testing required? Y ☐ N ☐

If yes, list investigations:

SEROLOGY TEST:

Date of Serology tests: _____ / _____ / _____

Is there evidence that the contestant's blood is infected with the following viruses?

HIV (Human Immunodeficiency Virus) Y ☐ N ☐

Hepatitis B antigen (HBsAg) Y ☐ N ☐

Hepatitis C Y ☐ N ☐

CONTESTANT DETAILS			
FULL LEGAL NAME:		**DATE OF BIRTH:**	

CONTESTANT'S AUTHORISATION

I authorise the medical practitioner to:

- provide medical information to the Minister responsible for administering the *Boxing and Martial Arts Act 2000*.
- provide medical information to the Office for Recreation, Sport and Racing for the purposes of administering the *Boxing and Martial Arts Act 2000*.
- obtain details of my medical records from previous medical attendants.

Signature: _____

Print Name: _____

Date: _____ / _____ / _____

MEDICAL PRACTITIONER'S SIGNATURE

I have completed the above medical history and examination and have witnessed the contestant's signature.

Signature: _____

Print Name: _____

Date: _____ / _____ / _____

SUMMARY

I certify that the above individual is **FIT / UNFIT** (select one) to compete in combat sports contests.

Signed: _____
Medical Practitioner

Print Name: _____
Medical Practitioner

Provider Number: _____

Date: _____ / _____ / _____

Medical Practitioner's Stamp

Government of South Australia
Office for Recreation, Sport and Racing

CERTIFICATE OF FITNESS

Issued under the *Boxing and Martial Arts Act 2000* and *Boxing and Martial Arts Regulations 2015*

CONTESTANT DETAILS					
FULL LEGAL NAME:					
DATE OF BIRTH:					
SEX:	**FEMALE** ☐ **MALE** ☐				
RESIDENTIAL ADDRESS:					
SUBURB:		**STATE:**		**P/CODE:**	
PHONE NUMBER:					
EMAIL ADDRESS:					

REASON FOR MEDICAL EXAMINATION (select one)**:**

REGISTRATION ☐	**ANNUAL MEDICAL** ☐
Contestants must have negative HIV, Hepatitis B and Hepatitis C serology results.	Contestants must have negative HIV, Hepatitis B and Hepatitis C serology results.
Date of Serology: _____ / _____ / _____	Date of Serology (within the last six months): _____ / _____ / _____
Date of MRI Head: _____ / _____ / _____	Date of MRI Head (within the last three years): _____ / _____ / _____

Please select all the disciplines for which the contestant is registering/registered:

☐ Boxing ☐ Muay Thai ☐ Kickboxing ☐ MMA ☐ Other _____

I certify I have completed the required medical history and examination and witnessed the above person's signature on page 6 of the Medical Examination Form.

I certify that the above person is **FIT / UNFIT** to compete as a contestant in nominated disciplines.

Signed: _____
Medical Practitioner

Print Name: _____
Medical Practitioner

Provider Number: _____

Date: _____ / _____ / _____

Medical Practitioner's Stamp:

Government of South Australia
Office for Recreation, Sport and Racing

REFUSAL TO ISSUE CERTIFICATE OF FITNESS

Issued under the *Boxing and Martial Arts Act 2000* and *Boxing and Martial Arts Regulations 2015*

CONTESTANT DETAILS					
FULL LEGAL NAME:					
DATE OF BIRTH:					
SEX:	**FEMALE** ☐ **MALE** ☐				
RESIDENTIAL ADDRESS:					
SUBURB:		**STATE:**		**P/CODE:**	
PHONE NUMBER:					
EMAIL ADDRESS:					

STATE REASON(S) FOR REFUSING TO ISSUE A CERTIFICATE OF FITNESS:

Signed: _____ Print Name: _____
Medical Practitioner Medical Practitioner

Provider Number: _____ Date: _____ / _____ / _____

Medical Practitioner's Stamp

To be retained by Medical Practitioner (Copy provided to Contestant)
Medical Practitioner is required to submit a copy to the Minister for Recreation, Sport and Racing at ORSR.CombatSports@sa.gov.au